“A Difficult Tightrope to Walk”:

An Exploration of Therapists’ Experiences of Working with Suicidal Students in Higher Education

Sonia Kalsi

Middlesex University and Metanoia Institute

Doctor of Counselling Psychology

and

Psychotherapy by Professional Studies

2020

Abstract

A Difficult Tightrope to Walk: An Exploration of Therapists' Experiences of Working with Suicidal Students in Higher Education

Sonia Kalsi

Doctor of Counselling Psychology and Psychotherapy by Professional Studies

2020

Suicide has become a public concern and a high government priority in the UK in recent years. Universities across the UK have witnessed increases in student suicide and with growing demands for university counselling provision, suicide risk amongst the student population is an increasing concern for mental health professionals in higher education.

Existing research on suicide is dominated by quantitative research, which has mainly focused on the epidemiology of suicide and the identification of risk and protective factors of suicidal phenomena. Despite increases in mental distress and suicidality amongst students, research on mental health professionals working with this complex population is an area which has been largely neglected. Recognising the imperative need for research in this area, this study aims to address the significant gap in research by exploring therapists' experiences of working with suicidal students in higher education in the UK.

The study used a qualitative design with semi-structured in-depth interviews. Eight participants were selected purposively and interviewed regarding their experiences of working with suicidal students. The interviews were then transcribed and analysed for recurrent themes using Interpretative Phenomenological Analysis. Four super-ordinate themes, each with inter-related sub-themes, emerged from the interpretative analysis: Exploring suicidality; The context matters; What helps?; and Barriers to working with suicidality in university counselling services.

Participants' accounts provided valuable insights of working with suicidal students in the higher education sector and created a space for therapists to give voice to their experiences of working with the implicit phenomenon of suicide. This research has increased knowledge, awareness and understanding of working with suicidality in the higher education sector. The findings have implications for therapists and counselling services in higher education as well as universities themselves, and it is argued that the findings could assist heads of university counselling services in planning improvements to service provision for suicidal students and improve support for therapists working with this vulnerable client population. Finally, implications for Counselling Psychologists working in the higher education sector are explored as well as areas for future research.

Dedication

This thesis is dedicated to everyone who has been affected by suicide in some way. I hope this thesis encourages increasing space for dialogues about suicide.

Acknowledgements

I would like to acknowledge the help of the following people who have supported me professionally through this doctoral journey: Dr Andrew Reeves, Dr Saira Razzaq, Dr Patricia Moran, Ladan Ghiami, Dr Vanja Orlans, Sarah Hall and Maria Papaspyrou.

I would like to thank my family and friends for their patience and support during what has been one of the most challenging periods of my life. I am also eternally grateful to Kuljeet who is an inspiration to me on a daily basis.

Finally, I would like to thank the participants of this study who showed tremendous courage and strength in talking about a subject that others might shy away from. I am grateful to them for their honesty and trust in sharing their stories with me.

Contents

Chapter 1-Introduction **8**
Overview **8**
The Current Landscape **8**
Contextualising the Research in relation to Counselling Psychology **10**
Research Aims, Objectives and Question(s) **12**
Research aims 12
Research objectives 13
Research question 13
My Relationship to the Research Topic **13**
Chapter 2-Critical Literature Review **17**
Overview **17**
Suicide Literature **17**
Introduction to the literature 17
Historical overview of the suicide literature 19
Experiences of working with suicide 20
Facilitating factors in working with suicidal clients. 24
Barriers to working with suicidal clients. 25
Long-term effects of working with suicide. 27
Post-traumatic growth. 28
Organisational issues and suicide. 29
Suicide in the HE sector 31
Introduction to student mental health: the current context. 31
Suicide prevalence in the student population. 34
Risk factors for suicide in students 36
Historical overview of the student suicide literature. 37
Governmental responses to student suicidality. 38
HE and student suicidality. 39
The role of university counselling services in supporting suicidal students. 42
Rationale for the Current Study **44**
Chapter 3-Methodology **47**
Overview **47**
Research Design **47**
My philosophical positioning 47
Interpretative Phenomenological Analysis (IPA) 48
Phenomenology. 49
Hermeneutics. 50
Idiography. 52
IPA in practice. 52
Rationale for selecting IPA. 52
Limitations of IPA. 53
Consideration of alternative approaches 55
Data Collection **56**
Sampling 56

Recruitment. 56
Sample size. 58
Participants. 59
Semi-structured interviews 61
Interview schedule. 62
Interview process. 63
Data Analysis 64
Quality Issues 66
Sensitivity to context 67
Commitment and rigour 67
Transparency and Coherence 69
Impact and Utility 70
Ethical Considerations 70
Psychological wellbeing 71
Consent 71
Confidentiality 73
Ethical decision-making in practice 74
Chapter 4-Findings 79
Overview 79
Introduction 79
Superordinate and Subordinate Themes 79
Exploring suicidality 81
The phenomenon of suicide. 81
Assessing suicide risk. 85
The long-term impact of working with suicide. 87
The context matters 90
Organisational responses to suicide. 90
The university 'agenda'. 93
Universities' expectations of their counselling services. 97
Uncovering the multi-faceted layers of suicidal distress in universities. 98
Therapy challenges in HE. 102
What helps? 104
Sharing concerns. 104
Support from others. 105
Previous experience of suicide. 106
Self-care. 108
Barriers to working with suicidality in university counselling services 111
Working under pressure. 111
(Too?) Brief Model. 113
Managing suicide risk. 115
Working and communicating with external services. 117
Process Issues 120
Chapter 5-Discussion 123
Overview 123
Research Findings and the Existing Literature 123
A Metaphor: Walking the tightrope 123

Exploring suicidality 125
The context matters 129
What helps? 133
Barriers to working with suicidality in university counselling services 135
Other important observations 138
Training. 138
My process. 138
Research Implications and Recommendations for Practice 140
Therapists and care of suicidal students 140
Counselling Psychologists in HE 143
University counselling services 145
HEIs 146
General public 148
Critical Evaluation of the Research 148
Strengths 148
Limitations 149
Dissemination and Impact of Research 151
Dissemination activity 1: Survey for Heads of University Counselling Services 151
Survey dissemination. 151
Survey findings and reflections. 151
Dissemination activity 2: Presentation of findings to a university counselling service 153
Reflections on research dissemination 154
Areas for Future Research 154
Chapter 6-Summary and Conclusions 157
Overview 157
Summary of the Main Findings 157
My Research Journey 159
Concluding Comments 161
References 164
Table of Figures 191
Glossary of Terms 191
Appendices 192
Appendix 1: Literature Search Strategy 193
Appendix 2: Recruitment Advertisement for Interview Participants 195
Appendix 3: Participant Information Sheet (PIS) 196
Appendix 4: Email sent to Potential Participants 198
Appendix 5: Description of University Types 199
Appendix 6: Interview Schedule 200
Appendix 7: Interview Introductory Guidelines 203
Appendix 8: Ethical Approval Letter 204
Appendix 9: Consent Form 205

Appendix 10: Sample of an Analysed Transcript.....206
Appendix 11: Sample of Emergent Themes for One Participant.....214
Appendix 12: Sample of Themes Across Participants.....216
Appendix 13: Dissemination 1-HUCS Survey Design.....231
Appendix 14: Dissemination 1-HUCS Survey.....232
Appendix 15: Dissemination 1-Recruitment Email for HUCS Survey.....234
Appendix 16: Dissemination 1-HUCS Survey Findings.....235
Appendix 17: Dissemination 2-Presentation Notes.....241

Chapter 1-Introduction

Overview

This research explores therapists' experiences of working with suicidal students in Higher Education Institutions (HEIs) in the UK. In this introductory chapter, I set the scene by briefly outlining the context of suicide within Higher Education (HE) and the aims, objectives and question of this research. Following this, I explore my relationship to suicide and conclude with some personal reflections on the research topic.

The Current Landscape

With university often described as the "best days" of one's life (Hastings, 2015; Thongbanthum, 2015), being a student is thought to represent a time when dreams can be realised. Sadly, the reality is quite different. In recent years, universities in the UK have witnessed a steady proliferation in the prevalence of mental health issues in the student population (Thorley, 2017). With the introduction of the Equality Act (2010), highlighting HEI's duties to provide support to students with mental health issues, the number of disclosures of mental health issues to HEIs has increased five-fold in the past decade (Thorley, 2017). It has been reported that students encounter increasing pressures at university which impact their mental wellbeing (Burns, 2017; Coughlan, 2016, 2018) and 15-24 years is recognised as the peak age for self-harming (Da Cruz et al., 2011). Despite concerns about student mental health and the risk of suicide being widely documented, attention has only really focused on self-harm and suicidality in HE in recent years (Universities UK (UUK), 2018).

Decriminalised in 1961, suicide is the second leading cause of death among 15-29-year-olds globally (World Health Organisation (WHO), 2018) and a report by UUK and Papyrus (2018)

confirms that student death by suicide is a global challenge. In 2011, the Royal College of Psychiatrists (RCP) (2011) identified suicide risk among the student population as an increasing concern amongst mental health professionals working in HEIs. Moreover, although suicide rates are reportedly lower for students than non-students in the general population, student suicide was reported to be at an all-time high in 2018 (Office for National Statistics (ONS), 2018), therefore highlighting the need for universities to pay greater attention to this phenomenon.

Presently, universities have an obligation to "pay due attention to potential risks to their student body and to take steps to minimise those risks when at all possible", (UUK, 2002, p.12). Therapists working in HE, too, have a duty of care "to work safely with suicidal students", (Reeves, 2005, p. 8). Nevertheless, it is clear that an involuntary death of a student, when it occurs, can be utterly incomprehensible to those working in HE, as Coren (1997) describes,

> Students and suicide have come to represent something heavily symbolic in our collective psyches. Young people who kill themselves, particularly if they are students, face us with the perennial and discomforting question, "why did he do it when he had everything to live for?" (pp. 89-90)

Another important consideration is that clinical practice with suicidal clients has been identified as one of the most stressful and anxiety-provoking areas of practice for health professionals, regardless of their level of experience (Kleespies and Ponce, 2009; Menninger, 1990). And yet despite this, suicide prevention and research have "not received the financial or human investment they desperately need" (WHO, 2014, p. 13). In light of this, it is unsurprising then that research on therapists' experiences of working with suicidal clients in university counselling services remains largely overlooked. The truth is that suicide remains a difficult subject to talk about, but with increasing concerns about suicide risk amongst students, it is impossible to neglect research in this area any longer.

Contextualising the Research in relation to Counselling Psychology

Before exploring the relevance of this research to Counselling Psychology, it is important to describe the structure of university counselling services across the UK as this will help orientate the reader to the research aims and question. Typically, university counselling services are comprised of student or university counsellor posts. These posts are generic in the sense that their remit is to provide psychological treatment/psychotherapy to students, as stipulated by the heads of university counselling services. Individuals recruited into such posts have qualifications in counselling, psychotherapy and/or psychology and are registered with their respective professional bodies i.e., British Psychological Society (BPS), UK Council for Psychotherapy (UKCP), British Association for Counselling and Psychotherapy (BACP) etc. For the purpose of this thesis, I am interested in exploring the experiences of all individuals who provide psychological treatment/psychotherapy to suicidal students in university counselling settings, regardless of their training, and therefore this includes counsellors, psychologists and psychotherapists. Regarding terminology, for ease and practicality, I have decided to use the term "therapist" to encompass all counsellors, psychologists and psychotherapists working in HE.

Although I am primarily interested in the experience of all individuals working with the phenomenon of suicide in a university counselling setting, I also acknowledge my identity as a trainee Counselling Psychologist (CoP). In completing a Counselling Psychology doctorate, I have a specific interest in the role that CoPs play in supporting suicidal students. Because of this specific interest, contextualising my research in relation to Counselling Psychology and the values of the profession is necessary.

Counselling Psychology is a branch of psychology which was initially recognised by the British Psychological Society in 1982, when it established a section of counselling

psychology, leading to full divisional status in the UK in 1994. As the accrediting professional body for Counselling Psychology, the BPS defines CoPs as a "relatively new breed of professional applied psychologists concerned with the integration of psychological theory and research with therapeutic practice" (BPS, n.d.). As a discipline, Counselling Psychology is strongly rooted in a relational stance and applied psychology, where attention is focused on psychological formulation, in order to improve psychological functioning and well-being (Jones Nielsen and Nicholas, 2015). It also endorses the scientist-practitioner model and pays close attention to human diversity. The Division of Counselling Psychology (DCoP) of the BPS has identified the following values which underpin the counselling psychology profession (BPS, n.d.):

- Being reflective scientist-practitioners
- Working creatively, compassionately and collaboratively
- Working ethically and effectively

CoPs work in a variety of sectors and although the majority work in the National Health Service (NHS), there are a number of CoPs who are employed in student/university counsellor posts in HE, as mentioned previously. Unfortunately, due to data not being collected centrally, it is not possible, at the time of writing, to provide a breakdown of the precise number of counselling psychologists currently working in the HE sector.

As a trainee CoP with direct experience of working as a university/student counsellor in HE for 7 years, I have a good understanding of the role of CoPs in HE. In my experience, CoPs have opportunities to engage in clinical work, supervision and service management, in the same capacity as their non-CoP counterparts. Because of such similarities, the research aims and question for this study are relevant to the clinical work, supervision and/or service management, provided not only by counsellors and psychotherapists, but also CoPs. Nevertheless, despite the generic role of a student or university counsellor, I anticipate that this study could make a distinctive contribution to the field of counselling psychology, and particularly to CoPs working in the HE sector. To elaborate, I believe that there is potential

for the values unique to the CoP profession, in particular in relation to the reflective scientist-practitioner model, to be developed further in supporting suicidal students, and I explore this more in the Discussion chapter.

Research Aims, Objectives and Question(s)

Research aims

The aim of this research was, essentially, to gain a rich understanding and awareness of therapists' experiences of working with suicidality in the HE sector. As discussed previously, the term "therapist" was used to refer to counsellors, psychologists (including counselling psychologists) and psychotherapists working in university counselling settings.

The research hoped to illuminate therapists' work with suicide in HE, increase understanding of the issues related to working with student suicidality, including the facilitating and impeding influences on the work, and the wider meaning that therapists attribute to their experiences of working with suicidal students.

This research also hoped to provide a space for therapists to give voice to their experiences of working with the phenomenon of suicide and help them reflect on their practice with suicidal students. The motivation for this study is aligned with Grollman (1971), as cited by Cholbi (2011), who observed that suicide is,

> ugly for onlookers, devastating for relationships, and harrowing even for those professionally involved, so the entire subject is often studiously avoided, even when a person threatens to take his own life. Some just do not want to become entangled in the sordid predicament. (p. 87)

Grollman's comments speak to the challenging nature of the phenomenon of suicide and the ambivalence which often accompanies it. My hope was that this research would go some way to challenge the stigma around suicide and open up a dialogue for therapists who work

with suicidality in HE.

Research objectives

The objectives of this research were to:

- Conduct in-depth semi-structured interviews with therapists on their experiences of working with suicidal students in HE
- Examine the facilitating and impeding influences associated with the work
- Analyse interview transcripts using Interpretative Phenomenological Analysis (IPA) and compile a list of themes which accurately reflected therapists' experiences

Research question

As a phenomenological piece of research which set out to explore therapists' experiences of working with suicidal clients in the HE sector, there was one broad overarching research question which underpinned this exploration:

What are therapists' experiences of working with suicidal students in the Higher Education sector in the UK?

To re-iterate, the term "therapist" was used to encompass all counsellors, psychologists (including counselling psychologists) and psychotherapists working in university counselling settings.

My Relationship to the Research Topic

This research used Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009), which is a methodology underpinned by reflexivity, a key aspect of idiographic knowledge. In line with IPA, it is important for the reader to gain an awareness of the lens through which the research will be interpreted and analysed, as that lens will be inevitably shaped by the experience, values and beliefs of the researcher. Acknowledging my active role in the research process, I wish to share my personal relationship to the topic with the reader.

My interest in student suicide has grown over the past 13 years during my time supporting students with mental health issues in HE. The journey and inspiration for this research started 10 years ago when I experienced a student suicide, in my role as a Mental Health Adviser. Prior to the suicide, although suicide risk assessment formed an important and routine part of my role, my naivety and sense of omnipotence blinded me to the possibility of suicide becoming a reality. The idea of a student actually completing suicide seemed inconceivable to me and I innocently felt immune to it. With this in mind, when the inconceivable became a reality, it changed my perception of the world forever and my place within it. The event impacted me profoundly. I was overcome by immense sadness, shame, guilt and fear. Moreover, a multitude of questions and doubts about my role and competency in working with suicidality ran through my mind; “Did I miss something? What if I got it wrong? Could I have done anything else? Will I lose my job? How will my colleagues respond? Should I leave the mental health profession?” The lines between reality and fantasy became blurred. Alongside my grief, I became aware of how my colleagues in the counselling team reacted to the suicide. In team meetings, I noticed how the topic of suicide was often brushed under the carpet or moved past in haste. My colleagues’ silence spoke volumes and I was struck by others’ avoidance or hesitation to “sit with” the suicide. This experience led me to consider, not only the powerful impact of completed suicide, but also the experience of working with suicide, both for the therapist and the wider counselling team in a university setting. I questioned if we, as mental health professionals, struggled to talk about suicide in in our team meetings, then what might be happening in our consultation rooms when faced with a suicidal student? Why was the phenomenon of suicide so difficult to process? And what did it mean for the institution that, those best qualified to deal with suicide, were in fact unable to talk about it? My curiosity was piqued as I asked myself, “Why does no one want to talk about suicide?”

Truthfully, the student suicide impacted me on a personal level too. It stirred something in me, which rose to the surface and demanded my undivided attention. What was it?...Looking

back, I think it was my own suicidal parts, which until then had remained dormant and unconscious. Not only did the student suicide force me to reflect on my personal views of suicide, it also gave me permission to explore my own suicidal parts. Thankfully, personal therapy helped me give voice to those suicidal parts, and through therapy, I recognised that my "darker" life experiences were, in fact, a source of strength and learning which allowed me to feel comfortable with sitting with others in their "darker" moments. In terms of how this translated to my practice, it meant that, over time, I learned to appreciate the realities of working with suicidal clients, and more importantly, my limitations as a therapist in working with the phenomenon of suicide.

The subject of student suicide has continued to be an area of interest for me, not only because I still work therapeutically with suicidal students, but also because suicides are increasingly a reality within the HE environment. These are worrying times for the HE sector and having experienced first-hand the high-pressured environments, which are characteristic of university counselling services, I am curious about the impact of the HE context on clinical practice. My hope is that this research will encourage all therapists working in HE to reflect on their therapeutic practice with suicidal students, a subject which, in my opinion, continues to be stigmatised and taboo. Given my own experience of feeling silenced, this research topic reflects my own deep-rooted desire to voice what is difficult or unspoken. To give voice to what is implicit or remains hidden, is, for me, at the very heart of what it means to be a therapist. My hope, therefore, is that this research provides a space for therapists to give voice to their experiences of working with suicidal students.

Moreover, suicidal students are a priority group for support and I strongly advocate that more must be done to meet their needs. Certainly, in my own professional practice, I have witnessed disheartening outcomes for those students presenting in crisis. With a keen interest in the support mechanisms for suicidal students, my hope is that this research will raise awareness and understanding of therapists' roles in supporting suicidal students and

issues related to working with suicide in HE. Finally, these findings have the potential to significantly impact at an institutional level by supporting policy development on managing suicide risk and development of good practice guidelines, with a view to improving future service provision for suicidal students in HE.

Finally, due to my personal connection to the topic, engaging in reflective and reflexive thinking has been extremely important throughout this entire research process. The reflexive process has been supported through discussions with my research supervisor, clinical supervisor, tutors and peers. I have also used a research journal to explore and bring into conscious awareness, my thoughts, feelings, values and beliefs in relation to the topic and the research process. Striving for transparency, a reflective commentary (with extracts taken from my research journal) is interwoven throughout the thesis.

Chapter 2-Critical Literature Review

Overview

In this chapter, I present a critical review of the relevant literature. The review focuses specifically on literature on therapists' experiences of working with suicide, organisational issues in working with suicide, and working with suicide in a HE context. Finally, I highlight gaps in the literature and offer a rationale for this study.

Suicide Literature

I used a variety of methods to search for relevant literature and details of my search strategy can be found in Appendix 1.

As mentioned in the previous chapter, this research focused on the experiences of all individuals who worked therapeutically with suicidal students in Higher Education. This included psychologists, psychotherapists and/or counsellors, however for ease and practicality, the term 'therapist' was used to denote the aforementioned professions.

Introduction to the literature

As therapists, we are in the service of life, and as such, we represent change and embody hope. In assuming this role, it is unsurprising then that suicidal statements are deemed the most stressful form of patient behaviour (Farber, 1983), and the most stressful clinical endeavour for therapists (Deutsch, 1984; Kleespies and Dettmer, 2000). In response to this, it seems reasonable to ask, "why is working with suicidal clients so stressful?" Linehan (1999) captures the complexities of working with suicidality,

> Therapy with suicidal patients is similar to walking a tightrope stretched over the Grand Canyon. Bending one direction, the therapist must act to keep the patient

> alive in the present. Bending in the other direction, the therapist must be careful not to respond in a manner that increases the likelihood of future suicide. Complicating all of this are the fears almost all therapists have of falling off the tightrope with the patient and of being held responsible for a patient's death if a misstep is taken and balance is lost. (p. 115)

Suicidal states are extraordinarily complex, as they are multi-determined and wax and wane over time. Moreover, "the existence and nature of suicide risk presents the practitioner with several ethical, moral, and practice dilemmas" (Reeves et al., 2004, p. 62) and poses major challenges to practitioners, due to its limited predictability (Hawton and Van Heeringen, 2009).

Several theoretical models have been developed to describe the pathways to suicide (Johnson et al., 2008; Joiner, 2005; Klonsky & May, 2014; O'Connor, 2011) in recent decades, and whilst it is not possible to summarise every theoretical model here, some theories of suicide do go some way to explain why working with suicidality is so challenging. Described as a "dynamic relational process with largely unconscious aspects" (Murphy, 2017, p. 88), some psychoanalytic authors suggest that the suicidal act is a split between the body and mind, where the body is experienced as a separate object, an "other", and becomes a theatre where one can play out their feelings. According to Laufer (1995), suicide is "carried out in a disassociated or transient psychotic state" (p. 115). Alexander (1991), too, describes a disconnection in suicidal clients, stating that "suicide is perhaps the most profound act of disconnection that a human being can undertake. It is a disconnection from one's own self and life from others who have been a part of one's life and from the community" (p. 277).

In psychoanalytic theory, it is proposed that individuals regress to a pre-verbal, paranoid-schizoid state, in which they project their anger, despair and anxiety outwards, in an attempt to communicate. Suicidal clients rely heavily on projective identification (Malin and Grotstein,

1966), a concept introduced by Klein (1952), as both as a defence mechanism and as a means of communication. With the client only being able to communicate in feelings and not words, the suicidal client can elicit powerful responses that may not become directly conscious (Yaseen et al., 2013), and arouse strong emotions in their therapist (Maltsberger, 1984-5), leading to the therapist becoming a receptacle for the client's inner world (Modestin, 1987). Such unconscious processes have been thought to lead to complex countertransferential issues and pose difficulties in the therapy work. Whilst I appreciate differing approaches to conceptualising suicide, the psychoanalytic approach, for me, highlights a challenge regularly faced by therapists, one which is associated with working with disconnection and fragmentation in clients, and which begs the question, how to connect with someone who is disconnected.

Despite the challenges outlined above, the reality is that suicidal statements are encountered regularly in therapy (Deutsch, 1984) and dealing with a suicidal client is the most frequently encountered crisis by mental health professionals (Bongar, 1992; Buzan and Weissberg, 1992). Deemed an occupational hazard by Chemtob et al. (1988b), suicide is something which all therapists will encounter at some point (Milton and Crompton, 2001). Existing research certainly supports this, with reports that the vast majority of therapists will experience a client attempting and/or completing suicide at some point in their careers (Brown, 1987; Chemtob et al., 1988b; Pope and Tabachnick, 1993: Werth and Liddle, 1994).

Historical overview of the suicide literature

It is widely acknowledged that the subject of suicide has been discussed and debated for several centuries. Sociologist, Durkheim, was a significant contributor to the discourse of suicide. In 1897, in his study, 'On suicide: A study in Sociology', Durkheim argued that suicide was tied to social structures driven by social causes (Durkheim, 1897, 1952). Later, in 1910, the Vienna Psychoanalytic society held a symposium, "On Suicide", during

which Freud shifted the discourse on suicide away from societal factors, and towards the internal world of the individual, namely, the inner fantasies and theories about the unconscious. In his paper, “Mourning and Melancholia”, Freud (1917) pointed to inner conflicts in human beings and proposed that every human possessed a “life instinct” with impulses toward creativeness, and a “death instinct” or “eros”, with impulses towards destructiveness. Furthermore, Freud (1917, 1923) stipulated that suicide originated from destructive wishes towards an internalised hated object, which were then directed against the self.

Since that time, North America has pioneered research on suicide. The majority of suicide literature, to date, has been mainly quantitative in nature and focused on areas such as suicide risk assessment, prediction, techniques, interventions, and crisis management strategies (Bongar, 1992; Firestone, 1997; Maltsberger and Goldblatt, 1996; Maris et al., 2000). Since the 1980s and particularly in the US, there has also been frequent reference to the need for “postvention” (Webb, 1986), a term coined by Schneidman (1975) to describe activities to reduce the impact of suicide. Lastly, research on suicide has not just been limited to psychotherapy but also extended to a variety of disciplines including medicine, psychiatry, nursing, psychology and sociology (Westefeld et al., 2000).

Experiences of working with suicide

Existing research on working with suicide has centred on the impact of completed suicide, and very little research has been undertaken on working with suicidal clients (Aldridge, 1998; Firestone, 1997; Pritchard, 1995). A metanalysis by Winter et al. (2009) has located only six studies on therapists’ experiences of working with suicidal clients: two on dialectical behaviour therapy (Araminta, 2000; Perseius et al., 2003); two on counselling (Reeves et al., 2004; Reeves and Mintz, 2001); one on psychodynamic interpersonal therapy (Colbert, 2002); and lastly one on psychoanalytical therapy (Rubenstein, 2003). In addition to this,

research on working integratively across a variety of theoretical models has been lacking from the literature.

Regarding therapists' experiences, research has revealed that therapists experience more negative feelings towards imminently suicidal clients than non-suicidal ones (Yaseen et al., 2013). Guilt and shame have been thought to be inextricably linked to suicide, particularly a completed suicide (Gitlin, 2007). A particular "blame and shame" stigma, historically attributed to the therapist of the deceased client, originate from both surviving family members, as well as the mental health profession itself (Weiner, 2005).

One of the earliest studies showed that working with suicidal clients evoked varying feelings from anxiety, anger and frustration to concern and protectiveness (Gurrister and Kane, 1978). This finding was later corroborated by a seminal study by Reeves and Mintz (2001), who reported that the communication of a suicidal thought by a client led to anxiety, fear and anger amongst therapists. Therapists also reported a loss of sense of professional competence and professional impotence, fear of threat of litigation and accusation of malpractice, and anxiety regarding organisational policies on confidentiality (Reeves and Mintz, 2001). Although this study has provided a valuable insight into the subjective world of a therapist working with suicidal clients, the applicability of these findings is limited due to the study's reliance on a small sample size of therapists, all of whom were female, Caucasian and person-centred in their approach.

In spite of the scarcity of research in the area, the literature which does exist is very clear about the extent to which therapists experience high levels of anxiety and fear in response to suicidal clients (Fox and Cooper, 1998; Moerman, 2011; Panove, 1994; Richards, 2000) and its' potential to "threaten clinical judgment and contribute to problems in therapy" (Hendin et al., 2006, p. 71). Underlying causes of anxiety in therapists have also been explored, and aside from death-related anxiety (Birtchnell, 1983; Hendin, 1981), heightened anxiety has

also been attributed to the stigma of losing a patient and the fear of emotional trauma of loss (Fremouw et al., 1990). A fear or threat of litigation or accusation of malpractice (Fremouw et al., 1990; Reeves, 2010) has also been suggested, a fear justified by the fact that client suicide is considered to be one of the leading causes of malpractice litigation for mental health professionals (VandeCreek and Knapp, 1989), with 25 % of family members of suicidal clients taking legal action against the client's mental health treatment team (Bongar, 2002).

Anxiety has also been connected to the risk assessment process itself, and the risk that therapists carry when working with a client who wishes to end their life (Milton and Crompton, 2001). Risk assessment is a continuous task in therapy, and while this is mostly dictated by employing agencies, the assessment of suicide risk, nevertheless, remains one of the most challenging tasks the mental health clinician can face (Rudd et al., 1999). It entails asking difficult questions, engaging clients who can be ambivalent about seeking treatment, making challenging decisions based on uncertainty, and facing the possibility of a client death. Although various risk assessment scales for suicide exist, Leenaars' (2004) work suggests that the efficacy of risk assessment tools has changed little over time. None, to date, provide enough robust evidence to justify their routine use in clinical settings (Bolton et al., 2015) and the vast majority are limited by their reliance on client self-reports (Chan et al., 2016; Quinlivan et al., 2017). Moreover, reports have shown that 95 % of those deemed a high risk of suicide do not end their lives (Large et al., 2016).

In terms of other experiences of working with suicidal clients, therapists also report a heightened responsibility and dependency (Birtchnell, 1983). Suicidal clients can unconsciously draw therapists into taking responsibility for their life or death, which reflects an early maternal dependence, but this dynamic also intensifies emotionality, which can lead to therapists feeling that they have failed if something untoward happens (Campbell, 2008). Linked to this, feelings of impotence were reported amongst therapists in a New Zealand-

based study (Rossouw et al., 2011). In this study, therapists frequently referred to a sense of powerlessness which resulted from being confronted by their own humanness and mortality through working with suicidal clients (Rossouw et al., 2011). This sense of responsibility can be heightened in the event of a completed suicide. In the therapist's mind, suicide is often proof of one's incompetence or irresponsibility (Hawgood, 2015).

Interestingly, experiences of working with suicidal clients have been explored through the lens of countertransference in working with suicidality. Suicide, as a phenomenon, has been thought to evoke a strong countertransference in therapists (Richards, 2000) and because of this, countertransference has increasingly been recognized as an important factor in therapy with suicidal clients, despite receiving relatively little attention in the literature (Yaseen et al., 2013). With research focused mainly on negative countertransference in working with suicidality, Maltsberger and Buie (1974, 1989) initially identified malice and aversion as negative responses to working with suicidality. Later research confirmed other negative countertransference reactions which included fear, incompetence, anxiety, impotence and anger (Fox and Cooper, 1998; Leenaars, 2004; Reeves and Mintz, 2001; Richards, 2000; Trimble et al., 2000). Moreover, a large-scale study of 100 psychoanalytic psychotherapists, found that suicidal clients evoked hopelessness, sadness, anxiety, self-doubt and a sense of failure in therapists (Richards, 2000). These therapists also reported feeling compelled to act in specific ways, in that transference led to therapists feeling either pressured to take on roles which confirmed their clients' inner perception of others, or they became a receptacle for their clients' unbearable feelings (Richards, 2000). Yaseen et al. (2013), however, noted that therapists became notably more overwhelmed, distressed by, and to some degree avoidant of their suicidal clients.

Research also points to the potential influence of therapists' personal history of suicide on working with suicidal clients. A personal history of suicidal feelings, for example, has been found to potentially interfere with a therapist's ability to deliver appropriate crisis intervention

for suicidal clients (Neimeyer et al., 2001). Research on previous client suicides, on the other hand, have revealed quite different findings. Earlier work has shown that therapists with a previous client suicide were more protective of suicidal clients and more directive in their approach (Gurrister and Kane, 1978). Strikingly, Menninger (1991) reported that two out of three therapists changed their practice following a client suicide, working towards "more conservative, thoughtful treatment" (p. 218). McAdams and Foster (2000), similarly, noted an increased attentiveness to legal liabilities of work, more conservative in record-keeping, increased focus on potential suicidal cues, increased peer consultation and increased concern with death/dying. Some negative impacts on practice were also noted which included a marked increase in the hospitalisation of clients at risk of suicide (Gulfi et al., 2010; Hendin et al., 2001; McAdams and Foster, 2000), self-doubts about professional competency (Fox and Cooper, 1998; Hendin et al., 2001), professional identity concerns and fears of persecution (Tillman, 2006).

Gender differences in relation to therapists' responses to suicidality have also been examined. Studies on responses to a completed suicide have shown that female therapists experienced higher levels of shame and guilt than male therapists, needed greater consolation, and experienced doubts about their professional knowledge (Grad, 1996; Gulfi et al., 2010). These findings do not necessarily imply that males are not affected by client suicide, but instead, that they may simply be less likely to disclose any level of distress or to seek support from peers. Nevertheless, contradictory evidence by McAdams and Foster (2000) on gender differences in responses to completed suicide suggests that further research in this area is needed.

Facilitating factors in working with suicidal clients. Facilitating factors have been explored in relation to therapists' experiences of working with suicidal clients. Sharing experiences of working with suicide with others has been found to be a key facilitator, especially in the early stages of the therapy work (Carter, 1971; Litman, 1965). In fact,

Pieters et al. (2003) found that there was a reduction in the stigma around suicide, when therapists shared their work or concerns about working with suicide with others of similar rank. Talking to colleagues was also regarded one of the most helpful coping strategies for therapists following a client suicide (Trimble et al., 2000).

Similarly, the majority of research highlights supervisory support as a positive response to suicide, in addition to peer support (Brown, 1987; Chemtob et al., 1988b). Highlighting the benefits of supervision, McAdams and Foster (2000) reported that supervisors not only normalised supervisee's experiences, but also helped them manage any feelings of anxiety which could negatively impact future clinical work with suicidal clients. Supervision was also considered useful in reaffirming therapists' practice (Reeves and Mintz, 2001), which was necessary given the uncertainty surrounding suicide amongst therapists.

Finally, an increased self-awareness was found to be an important factor for therapists when working with suicidal clients, as well as a capacity to reflect on their feelings, attitudes and opinions about suicidal clients (Sommers-Flanagan and Sommers-Flanagan, 1995). In fact, research revealed that therapists who possessed a good awareness of their own beliefs were better equipped to manage suicidal behaviour in their clients, and an increased self-awareness of personal values around suicide led to reduced rates of burnout, improved professional practice for therapists, and improved self-care (Sommers-Flanagan and Sommers- Flanagan, 1995). The final point about self-care is particularly important as this is an 'ethical requirement' for any therapist and forms part of the ethical framework for good practice for professional bodies such as the BPS (2018), UKCP (2019) and BACP (2018). Reeves (2010), too, stresses the need to attend to one's own wellbeing and to take appropriate steps to improve it, particularly in the event of a client suicide.

Barriers to working with suicidal clients. Barriers have also been identified when exploring therapists' experiences of working with suicidal clients. Firstly, it has been

proposed that there is a worrying failure or reluctance among clinicians to explore suicidal thoughts in their clients (Cole-King and Lepping, 2010a; Feldman et al., 2007; Hendin et al., 2006; Oordt et al., 2009), and according to Reeves et al. (2004), few therapists actually name suicide explicitly. As mentioned previously, the discourse around suicide can be a difficult one (Leenaars, 2004) and evoke fear in many therapists. Nevertheless, research has suggested that fear in talking explicitly about suicide could be linked to the stigma attached to suicide, therapists' fear of pushing people towards suicide (Palmer, 2007), putting ideas of suicide in their clients' heads (Reeves and Seber, 2007), or concerns around breaking confidentiality (Reeves et al., 2004).

Secondly, it is widely acknowledged that therapist factors influence the process and outcome of psychotherapy (Garfield and Bergin, 1978), and with this in mind, research has focused on how personal attitudes towards suicide, held consciously or unconsciously by the therapist, can influence therapy work with suicidal clients, and in some cases, even prevent a full exploration of suicidal ideation (Mintz, 1968). With 81% of therapists believing in "rational suicide" (Werth and Liddle, 1994), it appears that therapists' attitudes towards death, dying, and suicide are almost as important as the client's, in determining the outcome of therapy (Hendin, 1981). Two studies (Reeves et al., 2004; Reeves and Mintz, 2001) in particular, have highlighted how a therapist's inner conflict with suicide could infringe upon effective treatment of the client. Other studies have found that therapists were more accepting of a suicidal decision, if it resulted from a terminal physical illness rather than a mental illness (Gurrister and Kane, 1978; Hammond and Deluty, 1992). Moreover, therapists with more accepting views of suicide (i.e. the belief that suicide is a personal right) were found to respond less appropriately to suicidal threats than those who viewed suicide as unacceptable, who gave more appropriate responses (Neimeyer et al., 2001). Unfortunately, this study failed to clarify what exactly constituted inappropriate or appropriate interventions. Instead, competence in choosing appropriate therapeutic responses to suicidal individuals was measured using the Suicide Intervention Response Inventory (SIRI)

(Neimeyer & MacInnes, 1981; Neimeyer & Pfieffer, 1994a), which was based on written and filmed assessments of crisis intervention skills (Neimeyer & MacInnes, 1981; Neimeyer & Oppenheimer,1983), and expert opinion of what constituted appropriate responses (Neimeyer & Bonnelle, 1997). Aside from this, the study presented limitations which included missing data, a reliance on cross-sectional data and a sample comprised of graduate psychology and counselling students (and therefore not representative of qualified therapists). Finally, age has been found to be related to therapists' attitudes towards suicide, with younger psychologists reporting greater confidence in working with suicidal clients and believing in the right of an individual to decide when to die (Gagnon and Hasking, 2012).

Other barriers associated with working with suicidal clients are therapists' self-doubts about competencies in dealing with the expression of suicidal ideation, which, in some cases, appear to be related to a perceived lack of risk training (Neimeyer et al., 2001; Reeves and Mintz, 2001). The quality of training is often called into question by therapists, as evidenced by a study by Trimble et al. (2000), in which the majority of therapists questioned the adequacy of their training. Although risk assessment skills are internationally recognised as an essential part of counsellor training (Neimeyer et al., 2001; Trimble et al., 2000), there is very little evidence to suggest that therapists are actually provided with opportunities to develop skills in risk assessment in the UK (Reeves et al., 2004). In fact, Reeves et al. (2004) reported that despite 95.8 % of trainees acknowledging the importance of risk assessment as part of their training, 47.8% of those trainees did not practice assessing risk within their curricula. According to Kleespies et al. (1993), training institutions have a responsibility to make training in the study of suicide and suicide risk management a more routine part of the educational process for therapists, particularly as 97% of trainees encounter client suicide ideation, attempts, or completion during their training years.

Long-term effects of working with suicide. In recent years, with professional burnout attracting increasing public and professional attention, an interest in the cumulative

effect of working with traumatized clients, including suicidal clients, has grown in the therapeutic community. Increased incidents of dealing with suicidal clients have been found to lead to Vicarious Trauma (VT) (Fox and Cooper, 1998; McCann and Pearlman, 1990). VT involves the indirect exposure to another individual's traumatic experiences (Molnar et al., 2017) leading to profound changes in the core aspect of the therapist's self (Pearlman and Saakvitne, 1995), altering their views of the world and of themselves, and affecting aspects of their therapeutic efforts. It is also possible for the therapist to develop a trauma reaction, secondary to the client's trauma (Trippany et al., 2004).

Research has confirmed that the more time therapists spend with traumatized clients (including those who are suicidal) and the greater their caseload, the higher their risk of developing VT (Pearlman and Mac Ian, 1995). Similarly, a therapist who overly engages empathetically with traumatized clients, can also be at risk of developing VT (Pearlman and Mac Ian, 1995). Although VT is a unique and inevitable consequence of trauma work, it does not reflect psychopathology in the therapist (Pearlman and Mac Ian, 1995). The cumulative effect of working with traumatized clients, however, can interfere with therapist's feelings, cognitive schemas, memories, self-esteem, and/or sense of safety. With a high co-occurrence of PTSD resulting from trauma exposure (Bongar, 2002; Meichenbaum, 1994, 2001), Kleespies et al. (2011) goes so far to say that psychologists, as healthcare professionals, might even be at an elevated risk for suicide themselves.

Post-traumatic growth. Studies on the adverse effects of trauma work have dominated the literature in the past, however, there has been little exploration of the positive effects of trauma work and as such, understanding of this process remains vague (Bartoskova, 2015). Nevertheless, existing research clearly supports therapists' experiences of (vicarious) post-traumatic growth (Tedeschi and Calhoun, 1995, 1996). Post-traumatic growth is the "psychological growth following vicarious brushes with trauma" (Arnold et al., 2005, p. 243). In other words, therapists have been known to experience positive effects

from their struggles in processing trauma work (Manning- Jones et al., 2015; Tedeschi et al., 1998) and by bearing witness to the trauma of their clients (Hernandez et al., 2007). According to Pearlman and Saakvitne (1995), trauma therapists can experience post-traumatic growth after witnessing their clients' heroic struggle and survival, through the meaning-making process of that experience (Janoff-Bulman, 1992; Linley et al., 2005; Triplett et al., 2012). Moreover, Tedeschi and Calhoun (1996) have succinctly categorised post-traumatic growth as changes in self-perception, changes in interpersonal relationships, and changes in life philosophy.

A client suicide can also provide opportunities for professional growth. It can stop therapists from minimising suicidal behaviour (Goldstein and Buongiorno, 1984), and lead to improved assessments and a more balanced view of clinical responsibility (Brown, 1987). More importantly, a greater awareness of the impact of suicide can result in an increased sensitivity to suicidality, more realistic appraisals in relation to clinical competence and a greater understanding of therapeutic limitations (Gutin and McGann, 2010).

Organisational issues and suicide. Within the suicide literature, attention has focused on the "individual" experience of working with suicidality, rather than the "collective" experience or organisational approach. Only a handful of authors have remarked on how organisations respond to and/or process suicidality. According to Reeves & Mintz, 2001, "the organisation is a powerful influence on how counsellors respond to suicidal intention, in that the organisation tends to define structures, policies, procedures and criteria for the counsellor to adopt in such circumstances" (p. 175). Reeves (2018), too, highlighted an institutional anxiety existing around suicide, and argued that institutions overcome this by trying to "pin down practice to reduce risks, by applying science to the process and retreating into tick boxes, procedural flowcharts and a manualised approach" (p. 24). Bell (2001), on the other hand, noted that an omnipotence around suicide existed in organisations. Bell (2001) highlighted that it was "easy for staff to become identified with an

omnipotence which dictates that it is entirely their responsibility" (p. 32), and explained that "institutions, where these difficult patients are managed. can easily themselves become vehicles for the enactment of these omnipotent processes" (p. 34).

The theme of blame also emerged in relation to organisational responses, especially in relation to a completed suicide. In such cases, Hendin et al. (2001) advised that institutional responses and case reviews from their institutions were "rarely helpful, offering either blame or false reassurance that the suicide was inevitable" (p. 2022). Cole-King and Gilbert (2011a) suggested that therapists could fall into the trap of attempting to "name and shame" following a suicide, thereby spreading fear throughout an organisation. In light of this, Misch (2003) highlighted the need for psychological biopsies and institutional reviews to be conducted sensitively, or otherwise they could risk becoming an opportunity for finger-pointing.

Furthermore, research indicated that the organisational context, itself, was found to play a key part in therapists' clinical practice when working with suicidal clients. To be more precise, Reeves and Mintz (2001) found that the organisational context shaped therapists' decisions about how and when to break confidentiality with suicidal clients, and the implications of a suicide for the organisation led to heightened anxiety and sense of responsibility amongst therapists (Reeves and Mintz, 2001). Overall, research undertaken in this area pointed to the possibility of conflicting agendas existing between therapists and their organisations. For example, Fox (2011) identified that organisational policy and/or context presented significant challenges for therapists and noted a complex interplay between balancing expectations from the agency and therapists' personal ways of working. In order to avoid conflicting agendas, Reeves (2010) suggested that therapists working in larger institutions, tailor their responses in line with their organisational policies.
Lastly, there is evidence to suggest a possible link between organisational factors and client therapy outcomes for suicidal behaviour. Falkenström et al. (2018) noted a number of

organisational factors associated with improved therapy outcomes with suicidal clients, which included low conflict and high co-operation among staff, therapists' perceived engagement in and satisfaction with their work, clear role definitions, and low emotional exhaustion. Suicide risk was also found to be reduced, when therapists received support from their team and organisation, and when a clear management plan was in place (Keval, 2003). In particular, Keval (2003) described the need for a safety net (comprised of the organisation, the therapist/team and the client), and advised that a careful consideration of all three aspects were needed when working with a suicidal client, in order to minimise the potential for splitting and/or blurring of professional boundaries.

Suicide in the HE sector

Introduction to student mental health: the current context. Despite traditional perceptions of education serving as a protective "buffer" to mental health issues, the HE sector in the UK has witnessed significant increases in student mental health issues in recent years (Grant, 2002; Phippen, 1995; Rana et al., 1999; Stanley and Manthorpe, 2001a; Waller et al., 2005). Research has found that university is a time of heightened anxiety (Cooke et al., 2006) and students' mental health seemingly worsens over time (Bewick et al., 2010; Cooke et al., 2006). Depression and anxiety symptoms are commonly reported among students mid-way through their degrees (Andrews and Wilding, 2004), with 63% of students reporting stress and anxiety which interferes with their daily lives (YouGov, 2016).

Firstly, it is widely accepted that the peak onset for mental health problems is up to the age of 24 (Kessler et al., 2007), with 50% of mental health problems being established by age 14, and 75% by age 24 according to the Mental Health Foundation. Given that the majority of mental health problems develop by the age of 24, this naturally places university students as a group which are at a high risk of developing mental health issues. Other factors

associated with increases in mental distress in the student population include academic pressure to achieve good grades (RCP, 2011) and the developmental challenge of transition to adulthood (Hunt and Eisenberg, 2010), a task which entails living away from home, making new friends, handling finances, adjusting to new learning regimes and creating a new identity as a student (Scanlon et al., 2010).

The actual academic environment, itself, can also lead to or exacerbate students' difficulties (Tinklin et al., 2005). Contributors to stress include a lack of understanding among lecturers, a culture where it is difficult to admit to having problems, lack of support for learning and poorly designed learning experiences. Moreover, universities have witnessed students working longer hours, less support for students due to higher staff-student ratios and staff work overload (Phimister and Archer, 2008).

Finally, students' help-seeking behaviour is another important factor contributing to increasing student distress. Although student counselling is thought to be effective when actually used by students, particularly for those who complete a course of counselling and have a planned ending (Connell et al., 2008), a sobering statistic reveals that only 12% of students who died by suicide were reported to be seeing university counselling services (Hubble and Bolton, 2019). Despite struggling with their mental health, students do not always seek treatment from university support services, often for a variety of reasons. Firstly, students are not always adept at recognising their mental state and "suffering in silence" can have a negative impact on their wellbeing (Roberts et al., 2000). Secondly, some students struggle to access support services due to lack of knowledge of the health care system (RCP, 2011). Thirdly, students with moderate mental health issues do not meet the threshold for NHS support, particularly with the NHS historically prioritising those with severe mental health issues (RCP, 2011). Next, continuity of care with the NHS can be problematic especially when students return home for long breaks between academic terms (RCP, 2011). And lastly, students may be unwilling to seek support from university support

services due to the stigma attached to mental health issues, resulting in mental health issues being left untreated. A fear of discrimination exists amongst students when disclosing mental health issues to their university (Clothier et al., 1994; Martin, 2010), with some students going to great lengths to hide their mental health issues and struggling to meet academic requirements (Martin, 2010).

Aside from the ever-changing student population, the HE sector has also changed considerably over the past 2 decades, and the way in which it has evolved has significantly impacted student mental health care provision in universities. The government policy of widening participation was introduced in the 1990s which aimed to increase access to HE, and a major policy change occurred, which highlighted HEIs' duties, under the Equality Act (2010), to provide reasonable adjustments for students with disabilities, including those with mental health conditions. Both of these changes led to increasing numbers of students with mental health issues entering university and accessing support services. This was supported by research by Broglia et al. (2017) who confirmed that increased demand for mental health support was linked to increasing numbers of people from disadvantaged backgrounds and with poorer mental health, attending university.

Whilst widening access has led to a greater sensitivity in universities towards students with mental health issues, suitable spending increases on resources have not always been allocated to accommodate for the aforementioned policy changes. The knock-on effect of limited resources has meant that the education sector has relied more heavily on statutory services in supporting students, even against the backdrop of NHS cutbacks (Phimister and Archer, 2008).

The HE sector has also witnessed a rapid period of market driven change over the past decade, with one of the most notable changes being the way in which the sector is now funded (i.e. government funding has shifted from grants to loans). With increases in student

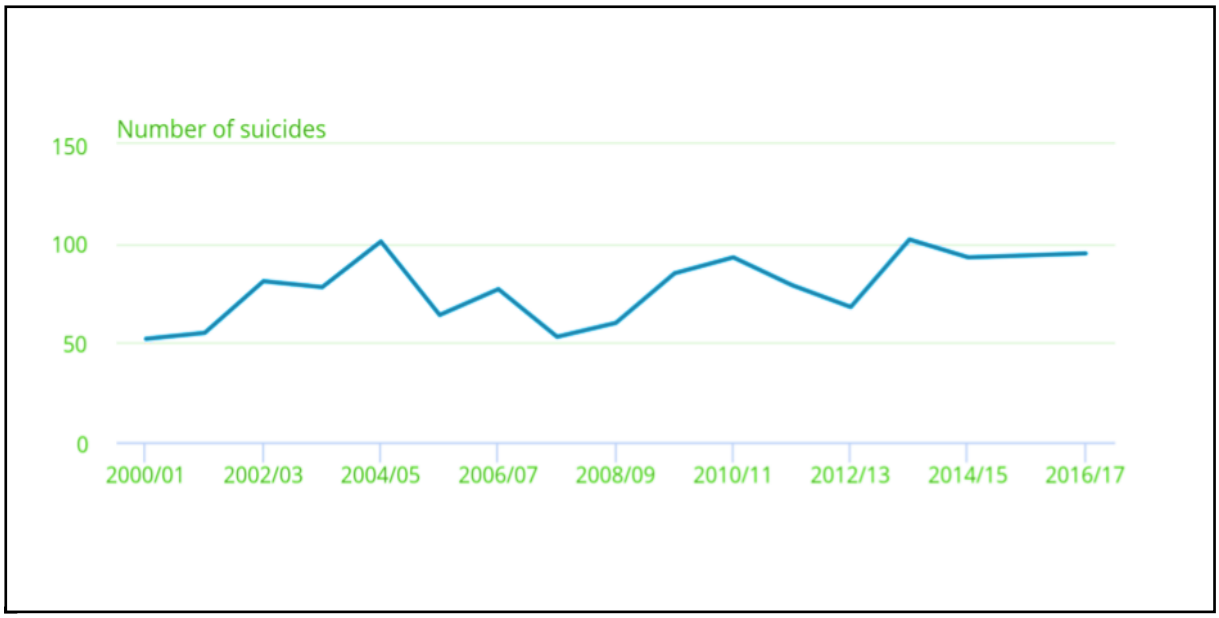
fees and heavy debt being a reality for students nowadays (Roberts and Zelenyanszki, 2002), changes in such government funding policies have negatively impacted student mental health (Jessop et al., 2005) and a significant relationship has been found between financial problems/debt and mental health amongst students (Fitch et al., 2011; Jessop et al., 2005; Roberts et al., 1999). Moreover, as a result of the aforementioned changes in funding, students are fast becoming consumers of education and with this role, potential complainants, with (often unrealistic) expectations of their university as a service provider (Jenkins, 2016).

Suicide prevalence in the student population. To date, there have been no national studies carried out into student deaths by suicide across UK universities over a sustained period of time. Moreover, historic data collected between the 1950s-1990s was only based on research conducted at single institutions, rather than at an aggregate level. Unfortunately, data collection on student suicide has proven problematic for several reasons: historically, suicide data has not been held centrally; difficulties in identifying student suicide in the national statistics (Stanley et al., 2007); problems with collecting data on suicides (completed and attempted) in universities; under-reporting of suicide; and, misclassification of deaths in coroner reports.

Nevertheless, recent statistics are concerning. A report by the Institute for Public Policy Research (IPPR) found that the number of student suicides in HE increased by 79% from 75 to 134 between 2007 and 2015 (Thorley, 2017). Following this, the ONS (2018) and Public Health England estimated that at least 95 student suicides were recorded in England and Wales in the 2016-17 academic year. (See Figure 1)

Figure 1

Number of higher education student suicides by year (ONS, 2018)



Note. *Deaths registered in England and Wales, between the 12 months ending July 2001 and the 12 months ending July 2017*

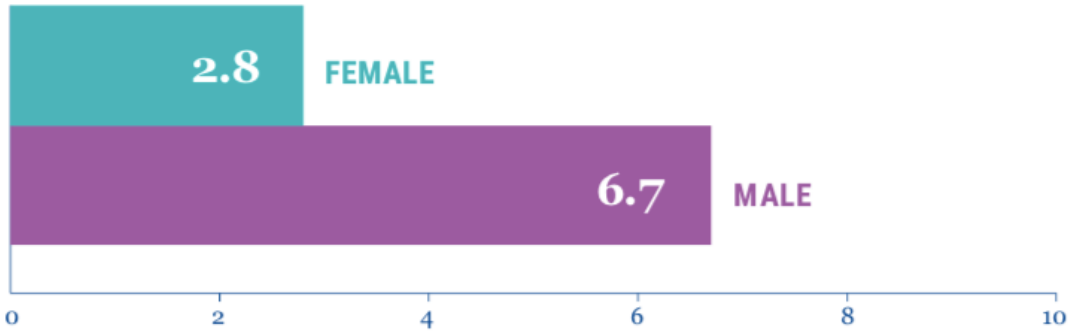
The ONS also found that male HE students had a significantly higher rate of suicide compared with female HE students. (Figure 2 below).

Suicide rates were also somewhat higher in undergraduates than post-graduates, however there was no evidence of an increased risk in people from ethnic minority populations.

It should also be noted that these statistics do not include suicide attempts, which could increase numbers in universities significantly.

Figure 2

Rate of Student Suicide by Gender (ONS, 2018)



Note. Rate per 100,000 of HE students

Risk factors for suicide in students. As mentioned previously, the majority of research on student suicide has focused largely on the risk factors for suicide in students. Social isolation, unemployment, depression, schizophrenia, drug and alcohol misuse and a history of sexual abuse and self-harm have been identified as "major risk factors for suicide" (UUK, 2002, p. 8). Student-specific factors which potentially increase the risk of suicide include disruption to studies, poor course attendance, financial pressures, alcohol and substance misuse (Hawton et al., 2012; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), 2017; Stanley et al., 2009). Research has also linked suicidality in students with perfectionism and fear of academic failure (Bell et al., 2010; Stanley et al., 2007; Stanley et al., 2009;), procrastination and achievement motivation (Klibert et al., 2011) and hazardous alcohol consumption (Heather et al., 2011). Transition, particularly at the start or end of an academic year has been found to be associated with suicide increase (Stanley et al., 2009). International students, in particular, can struggle with transition and increasingly report feelings of loneliness and social isolation, therefore placing them at a higher risk of suicide (RCP, 2011). Lastly, it is important to hold in mind that a significant percentage of the student population fall within groups of relatively high risk of

suicide and self-harm due to the age structure of the traditional student body, the high levels of reported drinking among students, particularly younger males, and the incidence of depression and other mental health difficulties amongst students (Grant, 2002; Rana et al., 1999).

Historical overview of the student suicide literature. An interest in student suicide originated in 1910, when Freud first chaired a symposium on college student suicide in Vienna, Austria (Slimak, 1990). However, it wasn't until the 1930's that the importance of the college years in the field of suicide research was recognised (Slimak, 1990) when Beeley (1932) conducted a study on college student suicide in an American college campus from a countrywide epidemiological perspective. Up until the 1970's, the majority of suicide research used small, unrepresentative samples which were deemed unreliable. Moreover, since the 1980s, the majority of literature on student suicide has been undertaken in U.S. universities and been limited to considerations of epidemiology, suicide prevention programming and studies of psychosocial factors of suicide risk in students (Jobes et al., 1997).

Here in the UK, comparatively few research studies have focused on student suicide or its' antecedents (Phimister and Archer, 2008). It is interesting to note, however, that a disproportionate amount of attention has been paid to completed student suicide, which is relatively rare, rather than students experiencing suicidal thoughts, which are relatively common (Heyno, 2008). Previous UK research has also focused on student suicide within a single institution such as Oxford (Collins and Paykel, 2000; Hawton et al., 1995). As a variety of organisational cultures can exist in institutions across the sector, research based on a single institution simply limits the extent to which the findings can be generalised. The limited research in this area, for me, points to a possible lack of awareness of or reluctance to acknowledge the problem of student suicide within the HE sector.

Governmental responses to student suicidality. Although mental health is a priority for the current UK government, the area of suicide awareness and prevention has made slow progress over the past 2 decades. The Foster report initially highlighted concerns about increases in student suicide to the UK government (Foster, 1995). Following the appointment of the Labour Government in 1999, two white papers, "Saving Lives: Our Healthier Nation" (Department of Health (DH), 1999a) and "National Service Framework for Mental Health" (DH, 1999b) were published, which set out to reduce overall suicide rates in the UK. The DH finally published its' first iteration of the Government strategy to reduce suicide rates in England in 2002 (DH, 2002), however it only referred to universities, in the context of a further consultation. A decade later, the coalition government published "Preventing Suicide in England: A cross-government outcomes strategy to save lives" (HM Government, 2012) and with momentum building around this topic, in 2015, Nick Clegg, the Deputy Prime Minster at the time, called for "zero suicides" across the NHS (DH, 2015).

It is important to stress that the aforementioned papers referred to suicide in the general population, and student suicide was only identified as a concern in the fourth annual progress report (HM Government, 2019a) which was published by the Government last year. During this time, the Government has been working directly with UUK, a key Higher Education employer association, the Office for Students, and other stakeholders to develop guidance on preventing student suicide. The fourth annual progress report recommended for the following actions to be taken by the Government:

- Analyse data on student suicides in England
- Work closely with UUK to embed the Step Change framework (UUK, 2017) which called on HE leaders to prioritise mental health and wellbeing and adopt a whole-university approach to mental health
- Support the development of guidance for universities on preventing suicides
- Support the sector-led Student Minds' University Mental Health Charter (Hughes and

Spanner, 2019) which encouraged universities to meet high standards of practice in health promotion and wellbeing

The Government also produced their first ever Cross-Government Suicide Prevention Workplan (HM Government, 2019b) which aimed to reduce the national suicide rate by 10% by 2020/2021. Moreover, two House of Commons briefing papers in August 2019 (Hubble and Bolton, 2019) and October 2019 (Mackley, 2019) focused on reducing student suicide, illustrate that the work around student suicide now appears to be gathering pace and the topic of student suicide is finally receiving much-deserved attention.

HE and student suicidality. The increased campaigning around suicide prevention in Westminster has been driven by the HE sector who, themselves, have started to pay greater attention to student suicide. Unfortunately, this does not translate to research endeavours and as such, literature on universities' "collective" experiences of responding to suicidal students is sadly lacking. Only a handful of authors discuss universities' responses to student suicide, and even then, most focus on completed suicides. Heyno (2008), for example, refers to universities' fear of blame, in the event of a student suicide, stating "this scrutiny, in terms of blame and projected guilt, is problematic for universities…it makes universities very cautious about talking and thinking about suicide and it creates a climate of fear in which suicide can become a taboo subject" (p. 177). Heyno (2008) alludes to universities being fearful, and to some degree, uncertain about how to deal with a student suicide. In contemplating the consequences of universities being fearful, Heyno (2008) suggests,

> If universities fear they will be publicly blamed when a suicide occurs, this can lead to an omnipotent fantasy that all suicide is preventable, and the entire responsibility for keeping students alive lies with the university…..Because it is an impossible task for universities to prevent student suicide, the omnipotent fantasy then gets projected onto student counselling services. (p. 177)

Although research is lacking, increasing concern around student suicide has led to universities developing or improving policies/guidelines on suicide prevention over the past 2 decades. Several reports have been produced in the HE sector to raise awareness of student suicide. In 2002, UUK and the Standing Committee of Principals (SCOP) (2002b) produced good practice guidelines in suicide prevention, based on the collaboration of 10 large universities and called for collaboration between the HE sector and the DH (Coxon, 2002).

Later in 2007, Papyrus, a youth suicide prevention charity, in collaboration with Kings College London and University of Central Lancashire, explored 20 case studies of student suicide using a multiple perspective approach (Stanley et al., 2007). The findings highlighted the need for greater inclusivity within the university and better communication between services in the aftermath of a student suicide. In 2010, the “Healthy Universities Network” was formed in response to these findings, which embraced a shift towards a holistic integrated model of health, using a “whole-university approach” to mental wellbeing (Healthy Universities, 2010).

Finally, an influential report by the RCP in 2011, placed student suicide at the top of the agenda for most universities. Not only did it identify student suicide risk as an increasing concern amongst mental health professionals working in Higher Education, but it also underlined the “pressing need” for increased provision for suicidal students.

More recently, the UUK and Papyrus (2018) published a “Suicide-Safer Universities” guidance for universities on preventing student suicides. Encompassing a “whole-university approach” framework, this document urged universities to make suicide safety an institutional priority by making a suicide-safer strategy and action-plan in collaboration with third parties (e.g., parents, expert organisations, stakeholders. etc) and offering suicide intervention and awareness training to staff.

With a growing public narrative which points to a crisis in students' mental health, and centres around frequently reported anecdotes of long delays in accessing university counselling, and unsettling reports of student suicides, it is impossible for the sector to ignore the topic of student suicide, and so, for the first time in decades, universities are starting to talk about suicide. The desire to engage in a discourse about suicide has been evidenced by the University of York who, in May 2016, disclosed that 50% of their total emergency callouts were due to self-harming and suicide attempts, an increase from 32 % in the previous year (Coughlan, 2016).

This motivation to talk about suicide may, in part, be driven by increasing media interest in student suicide, which can often be intense following a student suicide, and often accompanied by a wish to find something or someone to blame (Heyno, 2008). The shift in the discourse of student suicide and student mental health is mirrored in the increase of press attention on student suicide over the past decade (Figure 3).

Figure 3

Press articles on suicide in Higher Education

Student suicide increase warning

BBC News, 13 April 2018

Higher Education: Why do so many students commit suicide?

The Independent, 8 March 2013

Suicide is at record level among students at UK universities, study finds

The Guardian, 2 Sept 2017

The bold new fight to eradicate suicide

The Guardian, 1 Aug 2017

Funding fears as mental health demand soars

Times Higher Education 23 July 2015

Uni counselling services challenged by growing demand

The Guardian 27 May 2014

The role of university counselling services in supporting suicidal students.

While an increased discourse around suicide in universities is a promising sign, the issues impacting university counselling service provision for suicidal students appear to be complex and varied. Firstly, on a more optimistic note, Jenkins (2016) states that, due to an increase in complexity and severity of mental health issues in students, university counselling services are becoming a more integral and fundamental part of the university, rather than discrete, separate entities, as they were in previous years. Concurrently though, and perhaps disconcertingly, there is also an increasing move by some universities, to replace their counselling services and counsellors, with wellbeing services and less qualified staff (BACP, 2017). As a result of this, and its' status as a non-statutory service, university counselling services continue to be perceived to be a fairly vulnerable aspect of the wider university and consequently feel pressured to protect their services due to fears of outsourcing (Jenkins, 2016).

Questions, too, have been raised about the actual role of university counselling services in regard to student mental health. With university counselling services seeing "people with not too dissimilar levels of presenting problems and distress to those seen in NHS primary care services" (Connell et al., 2007, p. 55), the distinction between the NHS and university counselling is becoming more blurred than ever. Insufficient resources in statutory services raise further questions about the limitations of university counselling. The current financial climate of the NHS has resulted in reduced access to services and long waiting lists for psychological treatments, as well as more stringent entry criteria to specialist mental health

services (RCP, 2011; Thorley, 2017). Carver (2017) describes the dilemma faced by the HE sector,

> There is an optimistic assumption that universities are a natural place to locate student mental health support. Many students with complex and risky presentations need secondary care level services, but with thresholds so high in the NHS, they don't get access until they are seriously unwell. University services can't be expected to plug the gap in the NHS by default. (p.38)

As Carver (2017) explains above, expectations about university counselling can, at times, be intertwined in a wider debate about statutory mental health provision. Heyno (2004), too, highlights how universities' expectations of their counselling services play an important part in how these services perceive their role. University counselling services are,

> expected to protect the institution from all the unwanted publicity, perceived ignominy and psychic pain of a student suicide…Universities need counsellors to provide a receptacle for all the unacceptable, disturbing and unwanted aspects of the institution and the uncaring parts of themselves that they cannot consciously bear. (Heyno, 2004, cited in Heyno, 2008, pp. 177-178)

It is plausible that the way in which university counselling services manage these organisational projections has important implications for the management of suicidal students. As Heyno (2008) advises, although university counselling services need to accept that they carry all of the responsibility for the suicide risk, they do not need to act out, be persecuted or infected by the projections from the institutions themselves.

The issue of duty of care is another key consideration for university counselling services when working with suicidal students. It is important to point out that although therapists hold ethical and professional responsibilities to their students, these duties are not legally binding (Jenkins, 2016), with universities assuming a "moral duty", rather than a legal duty regarding suicide prevention (UUK, 2002). Concerns around duty of care appear to be partly fuelled by potential fears of litigation due to negligence, in the event of a student suicide. And yet,

despite increases in student suicides over time, there are no reports of increases in successful litigation against universities for alleged breach of duty of care (Jenkins, 2016), which implies that fears about litigation could be unfounded. In the US, a fear of litigation has led to some universities handing responsibility back to students to manage their mental health more effectively. The University of Illinois, for example, witnessed a reduction in suicides after introducing a policy which stipulated that students presenting a high risk of suicide, were required to attend 4 counselling sessions, and would be withdrawn from their courses, if they did not comply (Nelson, 2011).

Finally, the academic context, itself, presents challenges in therapy for therapists in HE. Working in an academic context, therapists tend to experience periods of "peaks and troughs" in regard to their workload which are determined by the academic calendar. The short-term nature of the work and the academic context also have significant implications for therapists' mental health, as Tarren (2016) explains,

> At worst, if counsellors fail to attend sufficiently to their own self-maintenance, there is the possibility, perhaps particularly in the short-term model within the pressured environments of HE with repeated, quick engagement and disengagement, for counsellors to suffer from burnout due to vicarious trauma. (p. 204)

Clearly, the pressures presented by the work environment point to the need for good self-care amongst therapists in HE.

Rationale for the Current Study

Research on therapists' experiences of working with suicidal clients, to date, has been limited (Aldridge, 1998; Firestone, 1997; Pritchard, 1995) and the phenomenological complexity of working with suicide has not been adequately captured. This is quite extraordinary, given that suicide is the most cited cause of anxiety amongst therapists (Menninger, 1990; Pope and Tabachnick, 1993). Although Reeves and Mintz's (2001) seminal study explored therapists'

experiences of working with suicidal clients previously, an exploration of working with suicidality within the HE sector has not yet been undertaken, and so, in this respect, therapists' experience of working with suicidal students is missing from the vast suicide literature.

There may be several reasons for the lack of research on working with suicide within HE. Firstly, the task of researching a sensitive topic such as suicide can be a challenging one, not only for researchers but also participants. The topic of suicide is still regarded as a taboo subject and given that research has shown that many therapists experience shame and guilt, particularly following a client suicide (Gutin and McGann, 2010; Sanders, 1984), it is safe to infer that therapists may be reluctant to openly discuss suicide for the purpose of research. It is also possible that therapists fear the implications of exposing concerns regarding suicide and might be fearful of attracting negative publicity to their institution through talking about suicide, especially when a "blame culture" is often rife in universities (Heyno, 2008). Finally, a lack of research in HE may reflect the sector's reluctance to acknowledge student suicide, and/or an unwillingness to support research in this area.

It is also interesting to note that whilst ample research exists on suicide in the student population, it focuses almost entirely on the students themselves. There is, presently, very little which addresses the experiences of those working with suicidal students, that is, the mental health practitioners. Whilst previous suicide literature sheds light on the complexity of working with suicidality and the aspects and themes which are important for therapists, the limited prominence of the voice of a therapist working in HE has not yet received an adequate platform. This pioneering research hopes to provide such a platform, offering unique insights in respect to therapists' work with suicidal students in the HE sector. Moreover, where previous research employed quantitative research methods, this study uses a qualitative design and interpretative phenomenological stance which allows for an in-depth exploration of working with suicidality and provides a thorough understanding of therapists' experiences of working with suicidal students. Finally, with increases in student

numbers (due to the concept of life-long learning firmly embedded in society), and evidence of increases in mental distress in the student population, research on working with this complex population is ever more pressing.

Chapter 3-Methodology

Overview

In this chapter, I introduce the research design which includes my philosophical positioning and my chosen methodology and its' theoretical underpinnings. I discuss the rationale for selecting the methodology, limitations associated with the approach and explore alternative approaches. Finally, I outline the data collection and analysis procedures and consider ethical and quality issues pertinent to the research.

Research Design

My philosophical positioning

I would like to begin by outlining my philosophical stance in relation to the research, that is, my epistemological and ontological position. Concurrent with discipline of counselling psychology, I am interested in understanding individuals' inner worlds and exposing subjective truths (Woolfe et al., 2009). My own philosophical assumptions are based on early philosophical ideas grounded in phenomenology (Heidegger, 1927/1962). I reject the positivist position which states that there is an absolute truth in this world, and instead believe that a number of different interpretations of reality exist. As such, I subscribe to the ontological position of critical realism (Bhaskar, 1978) which accepts that there are stable and enduring features of reality that exist independently of human conceptualisation. This position asserts that we can never know a reality with any certainty, and that all of our understandings of reality are essentially tentative. Knowledge of reality is partial i.e. contextual and local, and is mediated by our perceptions and beliefs, and interpreted through social conditioning. In other words, rather than seeing the whole picture, we only see as much as the linguistic and conceptual (social, political, and historical) factors of our social context will allow us to see. Moreover, the differences in meanings that individuals

attach to experiences are considered possible because they experience different parts of reality.

In applying this to research, a critical realist approach seeks to understand the meaning of an experience by reflecting on the wider social, cultural and psychological contexts, and acknowledges that data needs to be interpreted, in order to further our understanding of underlying structures which generate the phenomena under exploration. In a critical paradigm, the researcher's values play a central and directive role. They are not only an explicit component of the research endeavour, but also based in a sociocultural critique. The research is dependent on researcher reflexivity and their engagement with the text, all of which invokes a sense of discovery rather than construction within the analysis.

Interpretative Phenomenological Analysis (IPA)

The purpose of this research was to gain an in-depth understanding of therapists' experiences of working with suicidal students in HE in the UK and therefore a qualitative approach was considered the most relevant approach for this study. When designing my research, I also endeavoured to select a methodology which was consistent with my values and philosophical stance. After further consideration, I selected Interpretative Phenomenological Analysis (IPA) as it was a qualitative research approach that was compatible with a critical realist epistemology (Reid et al., 2005). As a phenomenological method, it was concerned with an in-depth exploration of human lived experiences and personal perceptions about a given phenomenon, and the focus remained on quality of experience and meaning making. Additionally, IPA involved the extensive and prolonged engagement with text in order to develop patterns and relationships of meaning (Moustakas, 1994). Smith (1997), the founder of IPA, defined IPA as "an attempt to unravel the meanings contained in accounts through a process of interpretative engagement with the texts and transcripts" (p. 187). The aim of IPA was to "explore how participants make sense of their

personal and social world" and the "meanings particular experiences, events, states hold for participants" (Smith and Osborn, 2003, p. 51). Individuals were considered to be "self-interpreting beings" who were actively engaged in interpreting the events objects, and people in their lives (Taylor, 1985). IPA draws upon three fundamental principles within philosophy; Phenomenology, Hermeneutics, and Idiography, all of which I will now discuss briefly.

Phenomenology. Phenomenology is concerned with exploring lived experience and focuses on how people perceive objects or events on their own terms, rather than according to pre-existing theoretical pre-conceptions. The founder of phenomenology, Husserl, famously remarked that, in order to describe and fully understand any given phenomena, "we must go back to the things themselves" (Husserl, 1900/1970, p. 252). For Husserl, this was only possible through a process of intentionality, the relationship between the process occurring in consciousness and object of attention for that process. Husserl also developed the concept of "epoche" in phenomenological inquiry, which involved the bracketing of one's preconceptions and assumptions and allowing the phenomena to speak for itself.

In critiquing Husserl's work, Heidegger (1927/1962), whilst in agreement with the concept of intentionality, argued that it was not possible for people to be meaningfully detached from their context. Heidegger (1927/1962) instead focused on the worldliness of our existence and described how human beings are thrown into a world of objects, relationships and language. Referring to this human existence as "being-in-the-world" or "Dasein", Heidegger proposed that our being-in-the-world was perspectival, temporal and always "in-relation-to" something. Consequently, this led to Heidegger (1927/1962) concluding that the interpretation of people's meaning-making was central to phenomenological inquiry. Finally, Merleau-Ponty (1962) highlighted that the body shaped the fundamental character of our knowing in the world. In exploring the embodied nature of one's relationship to the world, he noted how this resulted in the primacy of our own individually situated perspective on the

world. Focused on physical and perceptual aspects of body in the world, Merleau-Ponty argued that although we could have empathy for one another as human beings, we could never share others' experiences as others' experiences belonged to their own embodied position in the world. For Merleau-Ponty, the lived experience of being a body in the world could not be entirely captured or absorbed, but it also couldn't be ignored or overlooked either.

To conclude, according to Smith et al. (2009), it is through the use of phenomenology, that we gain an insight of human experience, in its own right. Although IPA aims to capture the quality of individual experience, it also accepts the impossibility of gaining direct access to individuals' worlds. As pure experience is never accessible and we can only witness the experience after the event, my only hope as a researcher, is to produce an account which is "experience close" rather than "experience far" (Smith, 2011).

Hermeneutics. Hermeneutics is the theory of interpretation (Langdridge, 2007). It was originally developed for the interpretation of biblical texts and gradually extended to the interpretation of a wider range of texts (Smith et al., 2009). Hermeneutic philosophers agreed that the "meaning of phenomenological description as a method, lies in interpretation" (Heidegger, 1962, p. 37). In fact, Heidegger and Merleau-Ponty also emphasised the situated and interpretative quality of our knowledge of the world. They asserted that interpretation was an inevitable and basic structure of our being in the world, in that we were always experiencing something that had already been interpreted.

IPA engages in a double hermeneutic process (Smith and Osborn, 2003) "whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith, 2011, p. 10). Drawing philosophically on interpretivism, the researcher's subjectivity is acknowledged throughout the research and therefore the final analysis is the researcher's interpretation of participants' experiences. Based on these

ideas, IPA seeks to generate knowledge about the quality and texture of experience as well as its' meaning within a particular social and cultural context.

The interpretation process itself involves reflection and a cyclical approach to bracketing (Smith et al., 2009). A circular process, known as the hermeneutic circle, is associated with meaning-making (Schleiermacher, 1998) and in this process of interpretation, the researcher moves in a circular motion from presupposition to interpretation and back again, as well as a repeated process of engagement with the text. As Tappan (1997) points out,

> The interpreter's perspective and understanding initially shapes his (sic) interpretation of a given phenomenon, and yet that interpretation, as it interacts with the phenomenon in question, is open to revision and elaboration, as the perspective and understanding of the interpreter, including his biases and blind spots, are revealed and evaluated. (p. 651)

The hermeneutic circle also describes the interactive and dynamic relationship between the "part" and the "whole" at a series of levels (Smith, 2007). As Schmidt (2006) explains, "parts can only be understood from an understanding of the whole, but that the whole can only be understood from an understanding of the parts" (Schmidt, 2006, p. 4). In practice, this means that interpretation occurs on a number of levels (i.e. from single word to sentence, sentence to complete transcription and/or transcription to the research in its entirety).

Interpretations can be driven by empathy or suspicion, or both (Ricoeur, 1970, 1996). Hermeneutics of empathy aim to get as close to participants' experiences as possible, whereas hermeneutics of suspicion aim to reveal a hidden truth behind participants' experiences. Although Ricoeur advised a combination of the two (Willig, 2013), Smith et al. (2009) support the use of an empathetic approach alongside a hermeneutic of "questioning", which allows researchers to gain insider's perspective (Conrad, 1987) by standing in participants' shoes, as well as standing alongside participants.

Lastly, researcher reflexivity remains at the heart of the interpretation process. In recognising the central role of the researcher, Smith (2004) does not advocate the use of bracketing. In line with this then, as an IPA researcher, instead of bracketing my assumptions about the world, I planned to use reflective and reflexive awareness and work with and use my assumptions, in an attempt to advance my understanding (Smith et al., 2009).

Idiography. Idiography refers to the in-depth analysis of single cases. Focusing on the particular rather than the universal, an idiographic approach offers insights into how a given person, in a given context, makes sense of given phenomenon. This is in direct contrast to nomothetic principles which underlie most empirical research, focus on groups and move towards making more general claims. Moreover, insights produced as a result of the engagement with individual cases, are only integrated in the later stages of research. In this way, IPA does not aim to produce findings which are generalisable, but instead focuses on the potential transferability of findings from one group or context to another (Hefferon & Gil-Rodriguez, 2011).

IPA in practice. In practice, IPA researchers have two main aims: firstly to listen intently to participants' experiences and gain an insider's perspective of the phenomenon under investigation; and secondly to focus on the interpretation of meaning i.e. what it means for those participants to have those experiences in that particular context (Larkin et al., 2006).

Rationale for selecting IPA. I considered IPA the most relevant methodology for my study for several reasons. Apart from being consistent with my philosophical stance, IPA was appropriate to the aims and the phenomena under investigation. According to Smith et al. (2009), IPA was best suited to a data collection method which would "invite participants to offer a rich, detailed, first-person account of their experiences…and facilitate the elicitation of

stories, thoughts and feelings about the target phenomenon" (p. 56). My study, too, was concerned with the detailed exploration, description and interpretation of the subjective experience, and the meanings given by participants (Willig, 2013). Moreover, the cyclical, interactive process appealed to me as it offered a dynamic way of working, allowing for a deeper immersion within the data.

IPA's accessibility, flexibility and applicability also provided a robustness as a research methodology, which was important to me given the fragility of the subject matter under investigation for this study. I was aware of my need for structure around what I considered a very sensitive and complex subject. IPA offered a detailed and comprehensive guide on the stages of analysis (Smith et al., 2009), a systematic analysis and clear guidelines, all of which provided me with the necessary structure and reassurance which was helpful to a novice researcher like myself.

The value of using IPA to explore an under-researched topic has been highlighted previously (Reid et al., 2005), and I was particularly mindful of this, given that research on working with student suicidality in HE, to date, has been so limited. Finally, I was aware that IPA was a well-researched approach, and with 294 empirical papers published on IPA between 1996 and 2008, this pointed towards its increasing popularity (Smith, 2010) and its' arguably dominant position in qualitative research (Smith, 2010; Willig, 2013).

Limitations of IPA. Despite the benefits highlighted above, IPA has also presented some limitations. Firstly, the role of language has been highlighted, in that this methodology relies heavily on participants' capacity to articulate (possibly) complex thoughts and feelings, and communicate their experience using language. Phenomenological research makes the assumption that language provides participants with the tools to capture the experience, however it has been argued that language is responsible for constructing a reality rather than describing it. In critiquing IPA, Willig (2013) argues that language can never simply give

expression to experience, and that it is through the use of language, that we understand how the participant talks about the experience rather than the actual experience itself. Although I appreciate Willig's (2013) critique about language, I consider that language is the means through which I can begin to understand participant's experiences of a phenomenon and agree with Smith et al. (2009) who states that "our interpretations of experience are always shaped, limited and enabled by, language" (p. 194).

Secondly, this methodology raises questions about how effective participants are in communicating the intricacies of their experiences in an interview context, especially if they are not familiar with talking about the phenomenon in such depth (Willig, 2013). It is fair to assume that describing accurately the subtleties and nuances of their physical and emotional experiences, through the use of language, is a difficult task in itself. To support this, Jaeger & Rosnow (1988) emphasise the limiting nature of language and question whether some words even exist to fully convey individuals' experiences, thereby creating barriers to a deeper understanding of phenomena.

Thirdly, although IPA sets out to describe, explore and understand individuals' experiences, it does not attempt to explain why people experience certain phenomena in certain ways, which had the potential to limit my understanding of the phenomena. As Willig (2013) explains, an awareness of the conditions (i.e. past events, histories, social/material structures within which we live) which give rise to experiences, form an important part of understanding the experiences themselves.

Finally, interpretations can be potentially limited or constrained by my own ability to interpret, reflect and make sense of the data (Brocki & Wearden, 2006). I have questioned my own interpretive skills, not only in being a novice researcher, but also in light of my previous relationship with suicide. A research journal has been helpful in this respect, allowing me to reflect on my interpretive skills and the interpretative process.

Consideration of alternative approaches

The aim of this research was to explore individuals' lived experience, personal meaning and sense-making in a given context. This could have been achieved through other highly regarded methodologies aside from IPA, which will now be discussed.

Descriptive phenomenology, developed by Giorgi (1992), is similar to IPA in that it also attempts to capture the nature or "essence" of a phenomenon. Although I appreciate the descriptive purpose of phenomenology, I favoured IPA's interpretative nature as it fully acknowledged the role of the researcher in the sense-making process. In addition to this, phenomenology encompassed Husserl's concepts of "epoche", a process whereby the researcher completely suspends and brackets their assumptions, which, again, was at odds with my own philosophy and therefore incompatible with my study and practice.

Grounded theory could have also been used to investigate the phenomenon in question. Constructivist grounded theory (Charmaz, 2006) is the most widely used in psychology, and has multiple versions. Grounded theory, essentially, aims to develop a theoretical account or more conceptual explanatory level of a particular phenomenon (Smith et al., 2009) and individual accounts are then drawn on, to illustrate theoretical claims. Although IPA and grounded theory share many similar features (such as identifying themes and categories that are progressively integrated into higher order units), I had a preference for IPA over grounded theory for several reasons. Firstly, despite grounded theory being a more established and better-known qualitative method, I was mindful that the grounded theory approach required work of considerable scale. For example, sampling on a relatively large scale meant investing a great deal of time and work, which was not deemed feasible for this small-scale study. Secondly, grounded theory was primarily developed to investigate social processes (rather than psychological processes) at a group level rather than at an individual level (Willig, 2013). Since my interest was centred around understanding the quality and

texture of individual experiences of phenomena, IPA's micro-analysis of individual experience appealed to me and offered me a more nuanced analysis of lived experiences.

Finally, discursive approaches could have been used to answer the research question. Discourse analysis also has multiple versions, all of which share a common concern with the constructive nature of language (Burr, 2003). Discourse analysis, for example, could have been used to explore how therapists constructed their experiences, however this methodological approach does not address questions about subjectivity and being closely aligned with a radical constructionist perspective, was not consistent with my epistemological position.

Data Collection

Sampling

Recruitment. In line with the theoretical underpinnings of IPA, the data was collected from a fairly homogenous sample. Participants were selected purposively, which involved locating a defined professional group, for whom the research problem had relevance and personal significance. For this study, this meant targeting therapists working in HEIs in the UK with experiences of working with suicidal students. I gathered the aforementioned sample through contacting the British Association of Counselling and Psychotherapy: Universities and Colleges division (BACP:UC), a leading national professional network for therapists working in HEIs across the UK.

Participants were recruited in January 2017 via an advertisement placed on the mailing list for members of the BACP: UC (Appendix. 2). The Participant Information Sheet (PIS), which outlined the purpose, methods and uses of the research, was also attached to the recruitment email (Appendix. 3). Once potential participants registered their interest in participating in the study, a follow up email was sent asking them to check their suitability

against the inclusion and exclusion criteria (Appendix. 4). In order to ensure a homogenous sample, I screened potential participants using the initial criteria below:

- Therapists currently working in any HEI in the UK (This criterion evidenced current clinical practice in the sector).
- Five years or more post-qualifying experience (Post-qualifying experience evidenced degree of expertise).
- Accreditation by the BPS, UKCP or BACP (Accreditation served as a benchmark and evidenced experience/expertise of phenomenon being investigated).
- Currently working with (or worked with in the past year) students that they believed to be suicidal (this criterion evidenced experience of phenomenon being investigated).
- Clinical supervision in place (this criterion was an ethical consideration to mitigate against any potential harm to the participant).
- Capacity to access to therapy, if needed (this criterion was an ethical consideration to mitigate against any potential harm to the participant).

Initial exclusion criteria

- Therapists with management responsibilities e.g. Head of Counselling and/or Senior Counsellor posts. (I excluded those with dual roles initially as I wished to focus primarily on therapists' lived experiences of working with suicidal students. I anticipated that the experiences of those with management responsibilities might be more nuanced and/or concerned with wider service issues and management concerns, rather than issues relating to their clinical work and role as a therapist).
- Trainee therapists. (I excluded this group due to their perceived lack of experience and expertise in working with suicide).

Throughout recruitment, my main aim was to locate suitable participants who would be willing to engage in an open dialogue about suicide. As I anticipated, however, the initial recruitment process proved challenging with a poor response rate. Although I suspected that

this was partly due to an unwillingness to discuss a sensitive topic like suicide, I also recognised that recruitment difficulties might stem from my inclusion/exclusion criteria: on the whole, those who did not meet the criteria were either in management positions or they were not accredited by the listed professional bodies. In light of this, I gave further consideration to the inclusion and exclusion criteria, in consultation with my supervisor, and made slight revisions, as shown below:

Amendments to inclusion criteria:

- To include accreditation from British Association for Behavioural and Cognitive Psychotherapies (BABCP)
- To include those registered with BACP (in addition to those accredited)

Amendments to exclusion criteria:

- To remove therapists with management responsibilities from the exclusion list. After much deliberation and in consultation with my supervisor, I decided that therapists in management roles should also be afforded the opportunity to discuss their experiences of working therapeutically with suicidal students. In the spirit of IPA, I wished to create a space for all therapists (including those in dual roles) to discuss any issues which they felt formed an important part of their experience of working with suicidal students. Despite my previous concerns that therapists with management responsibilities might be more concerned with wider service issues and management issues, I wished to maintain an air of curiosity and see what emerged from the data.

Following the revisions, I undertook a second recruitment drive which incorporated the changes above. A second email was sent out to the mailing list for BACP members in September 2017.

Sample size. Idiographic in nature, IPA does not seek to generate a theory which is then generalised over the whole population, and therefore a large sample is not usually needed. IPA studies usually focus on small sample sizes of three to six, which allow for in-

depth analyses of individual cases and experiences. In the cases of professional doctorates, however, Smith et al. (2009) recommend sample sizes between four to 10, which affords opportunity for exploration of both similarities and differences between individuals. After considering the recommendations above with my supervisor, I decided to recruit up to a maximum of nine therapists.

In total, 15 therapists registered their interest in participating in the study. Potential participants were informed that priority would be given to those on a "first come, first served" basis and those who met the criteria. Nine therapists met the criteria and were subsequently interviewed for the study. It is important to point out however, that although nine therapists were interviewed, one therapist was withdrawn from the study. Refer to the Ethical Considerations section later in this chapter for detailed reflections on my decision to exclude a participant's data.

Participants. This section introduces the reader to the therapists who participated in the semi-structured interviews, and on whom this research is based. To reiterate, this research is based on interviews with eight therapists in total. Of the eight therapists, one was male and seven were female. Regarding ethnicity, all of the eight therapists were Caucasian. Every therapist worked primarily to a brief model, as set out by their respective services. The locations of therapists were widely geographically spread; one from the South of England, two from the Midlands, four from the North of England and one from Scotland. Of the nine therapists initially recruited for this study, only one was in a managerial role and this therapist was withdrawn from the study on the grounds of uncertain continued consent to participate.

Respecting the idiographic nature of IPA, a brief précis on each therapist is provided below. Pseudonyms have been used to protect therapists' identities. The summaries do not form part of the analysis and they have been included in the thesis solely to add transparency and

context for the reader. Each summary includes the therapist's gender, type of university they work in (a brief description of each type of university is provided in Appendix 5), their theoretical approach and length of time working in HE.

Toby was a male therapist who worked in Russell group university. His theoretical approach was integrative psychotherapy and he had worked in higher education for 10 years.

Nadine was a female therapist who worked in a Russell group university. She practised Cognitive Behavioural Therapy and had worked in higher education for 11 years.

Helen was a female therapist who worked in a Russell group university. Her theoretical approach was integrative psychotherapy and she had worked in higher education for 22 years.

Beth was a female therapist who worked in a Pre-1992 university. She practised Psycho-dynamic Psychotherapy and had worked in higher education for 11 years.

Sophie was a female therapist who worked in a Pre-1992 university. Her theoretical approach was integrative psychotherapy and she had worked in higher education for 18 years.

Hannah was a female therapist who worked in a Russell group university. She practised Integrative Psychotherapy and had worked in higher education for nine years.

Cath was a female therapist who worked in a Russell group university. She practised Integrative Psychotherapy and had worked in higher education for five years.

Sue was a female therapist who worked in a Post-1992 university. She practised Integrative Therapy and had worked in higher education for 12 years.

Semi-structured interviews

In order to elicit rich detailed first-person accounts of working with suicidal students, I used semi-structured one-to-one in-depth interviews, the most widely adopted methods for IPA researchers (Reid et al., 2005). Being a novice IPA researcher, having a loose agenda served as a flexible tool in helping me guide discussions and provided me with some structure and safety in exploring a complex subject like suicide. Aside from producing rich data, the semi-structured nature of interviews also allowed participants to explore topics pertinent to them, whilst also ensuring that areas relevant to the research question were covered (Smith et al., 2009). I allowed up to 90 minutes for interviews, which provided sufficient time to build a rapport with participants and explore their experiences at a comfortable pace.

In the design stage, I also considered interviewing each participant twice as I felt that a second interview might allow for different experiences to emerge at different points in time and be an effective way to demonstrate trustworthiness. However, after discussing this with my supervisor and peers, I decided that this was not complementary to my methodological approach. Cognisant of knowledge being context-dependent, the task of exploring an evolving relationship between myself and participants, and its' influence on the data, was potentially a complex one. Also, in wanting to stay committed to an inductive approach, I was concerned that sharing my interpretations or specific quotes to expand upon with participants during second interviews could lead to analysis fuelled by my own concerns, rather than that of participants. Lastly, I also suspected that an increase in time commitment from participants might negatively impact recruitment and therefore the decision to proceed with one interview was affirmed, prior to the recruitment process.

Interview schedule. I drafted an initial interview schedule with the intention of allowing space for participants to tell their own story and to give expression to their experiences of working with suicidal students. During the early stages of designing the schedule, I considered the areas broadly pertinent to therapists' experiences of working with suicidal students, and then constructed questions which related these specific areas, whilst also paying attention to the sequencing and phrasing of the questions. As the purpose of the interviews was to encourage therapists to share their personal experiences of the phenomenon of working with suicidal students, I ensured that I used open-ended questions which were neutral and non-directive, and clear and concise language. In terms of sequencing, I attempted to use more descriptive questions at the beginning of the interview to help participants set the scene and provide context, and placed sensitive, personal questions towards the end of the interview when I anticipated that participants might be feeling more relaxed or comfortable with the interview process. Finally, I provided prompts where possible, to ease the interview process and encourage participants to elaborate further.

I ensured that the first draft was checked for content via an informal consultation with a "critical friend" (a counselling colleague who worked in an HEI). Following feedback from my "critical friend" and supervisor, a second interview schedule was developed and refined (Appendix 6). On reflection, this process of drafting and re-drafting was extremely important. This is because the initial interview schedule draft was heavily influenced by my own personal assumptions and experiences, whereas the final draft was more neutral, openly inviting therapists to discuss any aspect of their experience of working with suicidal students. Again, in the spirit of IPA, I did not wish to provide a definition (or my definition) of suicidal students as I did not want to impose my own views on therapists. I was aware that therapists' definitions of suicidality might differ, but in a sense, their definitions were not of importance. For me, it was more important that therapists decided for themselves what the term "suicidal" meant to them and explored their experiences in relation to this phenomenon.

Interview process. Interviews took place between March 2017 and November 2017 during office hours at therapists' places of work. i.e. support services sites on university campuses. I initially considered wondered whether being interviewed in their place of work facilitated or inhibited aspects of the interview process (if at all), however, on further reflection, I realised that ensuring confidentiality for interviewees was my main priority. In light of this, I specifically requested therapists to book a confidential and quiet space on site for our interview, which was free from interruptions or distractions, where possible. Although I allowed up to 90 minutes for interviews, the lengths of interviews varied from 85 minutes to 111 minutes. Informed verbal consent was obtained from participants before each interview commenced.

From the outset, I adopted a sensitive and empathetic approach and used my counselling skills to build a rapport with participants. The interview schedule was not followed exactly to the letter, in that questions were not asked in in the same chronological order for every interview. Instead, I encouraged participants to lead the conversations, and explored issues which were central to their experiences. I attended to participants' non-verbal communication to help guide me in my lines of enquiry and questions were adapted in light of their responses. This process allowed me to probe and explore important areas, as and when they arose. Wishing to avoid having a pre-scripted agenda, I also learned the interview questions in advance, which allowed space for creativity and spontaneity within the interview.

I was also aware, in my role of researcher, of a potential power imbalance between myself and the therapists. For this reason, I emphasised to participants that there were no right or wrong answers to any questions, and that I was more interested in learning about topics pertinent to their experiences of working with suicidal students, thereby giving them a sense of agency within the interview context. I was also careful not to make any personal disclosures because I wanted the focus to remain solely on participants' experiences and

wished to avoid setting up a comparative or competitive dynamic in the interview. I also wanted to ensure that participants received consistent information from the outset, and for this reason, they were provided with the same introductory guidelines to the interview (Appendix 7).

During the first interview, I noticed that achieving a balance between active listening and identifying pertinent topics warranting further exploration was a challenging process. Because of this, I decided to take notes during the interviews which followed. Aside from noting important themes or process issues which arose during interviews, I also noted observations about the relationship between myself and the participant (in order to contextualise the analysis), and my interview technique (in order to help support the development of these skills).

All of the interviews were audio recorded and a verbatim transcript of each interview was produced to aid with analysis. Despite the level of transcription for IPA being at the semantic level, i.e. the words expressed as opposed to prosodic aspects (Smith et al., 2009), I also noted any significant pauses and non-verbal utterances, e.g. laughing, to help with interpretation of the data, particularly any process issues.
Following transcription, I sent out a copy of the interview to each participant for them to check for accuracy, before commencing the data analysis.

Data Analysis

I analysed the data from semi-structured interviews, in accordance with the principles of IPA. As an iterative and inductive cycle (Reid et al., 2005), analysis in IPA is perceived as a "bottom-up" process in that the analysis process was an inductive one driven by data, rather than a deductive approach driven by existing theory and literature. The stages of this analysis, therefore, consisted of moving from a focus on the individual to a more shared

understanding of the group, as well as, from a descriptive level to a more interpretative one (Smith et al., 2009). With meaning central to IPA, the purpose of the data analysis was to understand the content and complexity of meanings rather than measuring their frequency, and this was only possible through sustained engagement with text and process of interpretation. I attempted to engage in an interpretative relationship with the transcript, paying careful attention to my own interpretative work in co-producing meanings with the participants. Rather than producing a definitive true reading of participants' accounts, I was mindful that IPA was a co-construction between participants and researcher and involved researcher's engagement with participants' accounts. I followed the stages of data analysis for IPA adapted from Smith et al. (2009), as shown below:

1) After transcribing the interviews, I immersed myself in the original data by reading and re-reading transcripts and listening to audio recordings. My aim was to gain insight into the participants' experience and perspective on their world. Ensuring that the participant remained the central focus of my analysis, I worked closely and intensively with each text, noting preliminary observations or reflections on content, language use, context and initial interpretative comments. I also noted my own personal reflexivity about the interview.
2) I coded each transcript with emergent themes. This involved identifying and labelling the themes which characterised each section of the text. The theme titles were conceptual & captured the essential quality of what was represented by text. Throughout this process, although I wished to stay as close as possible to participants' explicit meanings and experiences, I also shifted back and forth between participants' accounts and my own interpretation of the meaning of their accounts. With IPA's hermeneutic stance focused on inquiry and meaning making, I attempted to make sense of participants' attempts to make sense of their own experiences, thereby creating a double hermeneutic. A preliminary list of emergent themes was drawn up for every transcript through an iterative process, involving numerous re-readings of the transcript.

3) The themes for each interview were then integrated across all participants. This process involved searching for patterns across all interviews and identifying shared themes which captured therapists' experiences of working with suicide. I did so by tentatively and coherently organising the themes into clusters that shared meanings or references. The end product was a consolidated master list of superordinate themes (broader overarching themes) and subordinate themes (more specific themes) which reflected the experiences of the group, as a whole. Based on my interest and orientation, I was selective about what to retain or abandon. For example, some subordinate themes were discarded as they were not well-represented within the texts or marginal to the phenomenon of working with suicidal students. Inevitably, overlaps between some of the superordinate themes and subordinate themes existed, however every effort was made, where possible, to avoid repetition and to make relevant links between subordinate themes.
4) After a final draft of the master list of themes had been constructed, I selected verbatim quotes from the interviews to illustrate each subordinate theme.
5) The final stage was the writing up phase. During this stage, I translated the shared themes and patterns into a narrative account, detailing not only therapists' shared experiences, but also my own interpretative analysis of those experiences. When writing the narrative account, I phrased themes in a discourse-oriented way and tried to stay as close to participants' experiences as possible by using verbatim quotes to illustrate each subordinate theme and bring the text alive.

Quality Issues

Despite criticisms for "the space they afford the subjectivity of the researcher" (Madill et al., 2000, p. 1), qualitative research has tended to focus on the quality and rigour within research. Using terms such as credibility and trustworthiness (Golafshani, 2003; Stiles, 1993), quality measurement in qualitative research has been explored by a number of

researchers including Henwood and Pidgeon (1992) and Elliott et al. (1999). In regard to the quality of IPA research, Smith (2011) has produced criteria specifically for assessing quality, advising that validity needs to be applied flexibly due to IPA being a creative process. In particular, Smith refers to the work of Yardley (2000). Yardley (2008) highlights four principles which allow researchers to assess validity and complete good quality research: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. I will now discuss how I addressed each of these principles in my research.

Sensitivity to context

Elliott et al. (1999) highlight the importance of the specific context in which the participants are under study. I remained sensitive to context by reflecting on my own personal experience of student suicide. Also, having worked in a counselling service in HE for seven years prior to starting the research process, I was aware of the wider context in which the research was situated. Aside from my work experience, I also familiarised myself with the extant literature on working with suicidality and immersed myself in literature related to the theoretical underpinnings of IPA.

Commitment and rigour

Commitment refers to the degree of engagement with the topic under investigation for a prolonged period of time. I have been deeply engaged with this research since the initial seeds were sown in 2014. A lengthy planning process which spanned two years followed thereafter, and in 2017, after data collection, an in-depth engagement with the data analysis ensued which involved prolonged period of reading and transcribing interviews.

Rigour was achieved through several means for this study. Firstly, I demonstrated rigour by selecting a sample that was appropriate to achieving the aims of the research (Tracy, 2010). As discussed earlier in this chapter, and in line with IPA research, purposive sampling was

undertaken for this research, thereby ensuring a homogenous sample. Rigour was also shown through adopting a thorough and interpretative process of analysis (Smith, 2011), which I demonstrated in the findings chapter by identifying the prevalence of each theme and extracting verbatim quotes from participants. Finally, I demonstrated rigour by keeping an audit trail of the data (Meyrick, 2006; Smith et al., 2009), which would enable the reader to trace through my line of enquiry (Appendix 10,11,12).

Furthermore, in demonstrating rigour, I completed credibility checks (Elliott et al., 1999) by involving and consulting with others (supervisors, “critical friend” and peers) throughout the entire research process. Completing these credibility checks ensured that reflective and reflexive thinking formed part of the research process, thereby resulting in a credible piece of research. I also involved participants when sending them transcripts for checking. As the material was particularly sensitive, I wished to give participants the opportunity to review their interview transcripts and check for accuracy. Known as member checking, this process is a common means of ensuring trustworthiness. It is an honest strategy which allows participants to review what they said and add or edit the document, as necessary, which is essential given the sensitivity of the topic under investigation. Member checking can, however, present some disadvantages; not only can it increase the potential for participants to drop out and hence lead to the loss of valuable data, but it can also lead to participants cleaning up their data and therefore losing the immediacy of the data. After considering the possible disadvantages above, I accepted that some degree of attrition was always a possibility in research. My priority, as a researcher, was to be transparent about research process and respect the integrity of my participants, and therefore participants reading the transcript was one way of achieving this. Moreover, because of the sensitive nature of the topic under investigation, I felt it was even more important that participants were informed that they could retract any data at this time. Following the member checking process, the majority of the participants did not retract or change any data and they merely made minor corrections to spelling or acronyms. Only one therapist did not return the transcript and was

consequently withdrawn from study (this will be discussed in more detail in Ethical Considerations section).

Transparency and Coherence

Transparency relates to the "disclosure of all relevant research processes" (Meyrick, 2006, p. 803) from the point of sampling and recruitment through to the analytic process. I achieved a high level of transparency through providing a thorough and clear description of all processes undertaken, including details on the process of devising the survey, sampling and recruitment of participants through to the interview process and analytic process. I also produced a "thick description" of the data and provided sufficient details about participants, so that the reader could assess the relevance and applicability of findings to other contexts. Lastly, this study was grounded in multiple examples from the data in the form of verbatim quotes, where possible, and lists of codes and categories. Sections of coded transcript can be found in Appendices 10, 11 and 12.

Transparency also relates to self-reflexivity (Tracy, 2010) and owning one's perspective (Elliott et al., 1999). Stiles (1993) recommends transparency from researchers about their "personal orientation, context, and internal processes during the investigation" (p. 602), and in the same vein, I have explicitly stated my positioning as a researcher from the outset, including my personal values, interests and initial assumptions in order to assist the reader with interpreting the data. Given the strong reflexive premises embedded within IPA methodology, reflexivity has been stressed throughout this study and reflections (from my research journal) are included throughout the thesis.

Finally, coherence was shown through my endeavours to evidence an 'appropriate fit' between theory/research question and the chosen methodology within this chapter.

Impact and Utility

Highlighting the need for research to have a sense of importance and impact, Yardley (2000) argued that this final principle is "the decisive criterion by which any piece of research must be judged" (p. 223). Tracy (2010) asserted that this could be achieved through selecting a worthy topic. In light of this, I would argue that given the increases in student suicide in recent years, any research which increases our understanding of working with this client group is indeed worthy of the attention of researchers.

In terms of utility, as stated in the introduction, the findings from this study could go some way to provide a better understanding of the issues faced by therapists working with suicidal students and therefore help service providers to improve support, training and working practices for those working in the sector. This research could also encourage therapists to reflect on the possible implications of the findings for their own practice and inspire future researchers to continue with exploration in this important area.

Ethical Considerations

This study abided by the Code of Human Research Ethics for the British Psychological Society (BPS) (2014) and was granted ethical approval by Metanoia Institute's Research Ethics Committee in 2016 (Appendix 8).

In light of the sensitive nature of the phenomenon under study, I endeavoured to remain ethically attuned throughout the entire research process, including the research design and implementation stages. I viewed the research process as a dynamic and fluid process, in which new dilemmas presented themselves and considered ethical research practice to be much more than simple rule-following. I was also mindful of my ethical engagement throughout the entire research process and used research supervision, therapy, and my research journal to help reflect on any ethical issues as they emerged.

Psychological wellbeing

Participants' psychological wellbeing was at the forefront of this study and as such, my focus remained on minimising the potential for harm to participants, and particularly any intentional harm to participants, where possible. As a researcher-clinician, I planned to paid attention to the impact of interview questions on participants, as I was aware that speaking about issues relating to possible vicarious trauma could be re-traumatising for some individuals. In the event of any re-traumatisation, I planned to address any concerns about participants' wellbeing with sensitivity and respect and use my counselling skills as a qualified psychotherapist to offer support and minimise distress. Also, I ensured that participants were given opportunities to de-brief and ask questions at the end of each interview and discuss any concerns that arose from the interview process itself. If any serious concerns about wellbeing were raised during an interview, I planned to stop the interview and encourage the participant to seek further support through clinical supervision or access therapy in their local area. Despite the potential for harm or re-traumatisation in therapists, my hope was that the interviews would serve as opportunities to share personal experiences in an open and non-judgmental forum.

In light of my own experience of student suicide, I attended to my own self-care throughout this research process. Given the potential for re-traumatisation (based on my own experiences of student suicide), I regularly attended personal therapy concurrent to the research process, which allowed for any emotional issues emerging from the research process to be addressed and worked through as necessary.

Consent

Informed consent was an essential part of the research process as it provided protection for the rights and welfare of participants. The PIS clearly outlined the purpose, methods and uses of the research to participants and, where necessary, participants were encouraged to

contact me directly for further information.

Consent was initially obtained verbally from participants from the outset of interviews, and participants were also required to sign a consent form (Appendix 9). The consent form requested therapists to confirm that they had read the PIS and that they understood that their participation was voluntary and that responses would be anonymised.

I would like to stress that the issue of consent was an active and ongoing process. In other words, consent was continually monitored throughout the research process and obtaining informed consent involved a continuous re-negotiation of trust. Known as continued consent, this process involves "obtaining the consent repeatedly from the subjects, whenever required or indicated during the course of conduct of the study, even if the initial consent was obtained at the study entry" (Gupta, 2013, p. 29). Continued consent is not only supported and encouraged by my training institution, but also by leading professional bodies such as the BPS and BACP and experts in IPA, all of whom consider this good practice in qualitative research. The BACP (2019) Ethical Guidelines for Research in the Counselling Professions.asserts that,

> Consent is not a "one off" issue at the start of participation in research but will commonly require renewal as participants come to understand better what their involvement entails… research is an ongoing process, which may include new or unforeseen developments. Consent may therefore need continued discussion and clarification throughout the research, as events unfold and the research progresses. (p. 47)

Similarly, Smith et al. (2009) also support continued consent stating, "it is good practice to revisit the issue of consent within the interview itself, with specific oral consent being sought for unanticipated emerging sensitive issues" (p. 53). I subscribe to the idea that consent needs to be fluid and subject to change, particularly as participants gain a fuller appreciation of the research, and the nature of participation becomes more apparent during the course of

their involvement with the research. After all, I believe that “we don’t always know what we are signing up for, until we have done it”.

Part of informed consent includes giving individuals the right to withdraw from their participation in a study at any point. For this study, in valuing participants as autonomous beings, I informed participants of their right to withdraw from the research up to the point of completion of data analysis, and without explanation. This information was stated clearly in the both the PIS form and Consent form. The right to withdraw is, again, supported and considered good practice by professional bodies including the BPS Code of Human Research Ethics (2014) and BACP Ethical Guidelines for Research in the Counselling Professions (2019). Moreover, aligned with my own values, I appreciated the potential for research, being dynamic and subject to twists and turns, to diverge in a direction which could result in discomfort in participants or an unwillingness to continue.

Confidentiality

Participants’ anonymity was also protected throughout the research process. Personal information which could identify the therapists remained strictly confidential and I was the only person who had access to this information. All names and any identifying details of participants were changed in the transcriptions, using pseudonyms instead of real names. Full anonymity was also guaranteed in both written and verbal dissemination of the research findings. I also informed therapists, during their interviews, of the main steps that I would take to ensure confidentiality. All data was stored in accordance with university regulations and the Data Protection Act (DPA) (2018) and stored securely on an encrypted computer. When using extracts from the transcripts for the writing up, any identifiable or personal information was replaced with the letters XXX. Also, as audio recordings were taken to aid with analysis, therapists were informed that all audio recordings and transcriptions would be

securely stored without any identifiable information about them and destroyed on course completion.

Ethical decision-making in practice

Ethical decision-making can be challenging, particularly for novice researchers like myself. The complexities of ethics in qualitative research are illustrated and brought to life through presenting a major ethical dilemma which I experienced in this research process.

As mentioned earlier in the chapter, I decided to exclude one participant's data from the final analysis. Before discussing the ethical dilemma itself, it will be helpful to the reader to provide some context and outline the order of events. Post-interview, I sent every participant a copy of their transcript for checking and asked them to sign and return the consent form. The participant, in question, responded briefly to my prompts on one occasion, with reassurances that they would return the checked transcript and signed consent form, and apologised for the delay attributing this to being on sick leave from work. Following this, I offered the participant the opportunity to debrief, if necessary, however the participant did not respond. In striving for transparency, I sent the participant a final email stating that, if I did not hear from the participant within a specified time frame, I would have to withdraw them based on my assumption that they did not wish to continue participating in the study. The participant did not respond to this email, which left me with the dilemma of "Do I continue to use the participant's data without their explicit consent at that point **i**n the research process?" or "Do I withdraw them from the study with the risk of potentially de-voicing them?" When coming to a decision about whether to withdraw the participant's data from the analysis, I was mindful of a number of factors:

- I was aware of the participant's right to withdraw from the study without explanation. I referred back to the PIS, which was disseminated to participants at the outset of the research process, which informed participants about the research contract including

details on consent. The PIS clearly informed participants of their right to withdraw “up until the completion of data analysis and without explanation”.

- The turn of events regarding this participant raised important questions about consent. In terms of my position on consent, I wanted consent to be transparent and explicit, particularly in light of complex discussions around death and loss, and for this reason, full written consent post-interview was absolutely essential before starting the writing-up process. To recap, the participant gave verbal consent to participate in the study during the interview, made brief contact post-interview, and then stopped responding to my later emails. Moreover, the participant did not sign the consent form, as requested post-interview. Mindful of consent being continued in this study, I interpreted the participant’s non-communication and their inability to sign the consent form both as signs of passive form of withdrawal from the study and concluded that that they had opted out of the research process.
- Finally, I was acutely aware of the psychological impact of discussing suicide. Looking to the suicide literature (Gitlin, 2007), I appreciated that the sensitivity of the interview material could have led to therapists potentially experiencing shame in relation to suicide. Moreover, I was informed by the participant in the early stages post-interview that they had taken a leave of absence from work due to sickness. This left me with some doubts about the participant’s overall wellbeing.

In coming to a decision, I was mindful that the research process needed to follow not only course expectations around continued consent, but also be led by the literature. After a lengthy and complicated decision-making process, which involved consultation with my research supervisor, I decided to exclude the therapist’s data from the final analysis on the grounds of uncertain continued consent to participate. In reaching this decision, I felt I was able to maintain and safeguard the integrity of the research (e.g., research integrity could be compromised in cases where a participant has not followed the study procedures).

In terms of reflections and lessons learned, this ethical dilemma has highlighted the need for clear, explicit communication between researcher and participants throughout the entire research process. In particular, one of the key learnings is the need for greater clarity around consent and right to withdraw, from the outset of a research process. In my study, although I offered participants a time-limited right to withdraw, I could have been more explicit about the deadline. I informed participants that they could withdraw up to the point of completion of data analysis and I anticipated that this could be in May 2018, however I did not update participants on the exact deadline.

This dilemma has also raised questions about what constitutes a withdrawal from the study by researchers, especially when there is no explicit rejection by a participant. With hindsight, and in striving for greater transparency, it may have been helpful to have been more explicit about the limits to withdrawal from a study i.e. the point at which withdrawal of participants from the study by researchers would be considered.

In retrospect, I placed greater importance on consent to transcript checking than the possibility of wasting valuable data. Furthermore, on the issue of consent, it could be argued that gaining written consent at an earlier point of the research process i.e., before the interview, may have been more beneficial, and that by doing so, the dilemma around using the participant's data could have been avoided altogether. Although gaining written consent could have been beneficial for many reasons, I am aware that gaining written consent at an earlier stage of the research process would also have been at odds with the concept of continued consent, as encouraged by the course provider. It is also interesting to note differing perspectives on verbal and written consent. I am aware that some researchers subscribe to the notion of "consent is consent", meaning that written or verbal consent hold equal weight. Regardless of this, however, I understand that, in practice, written consent generally holds more weight than verbal consent.

Issues of power and control between researcher and participant were also highlighted through this dilemma. To elaborate, it is possible that participants may have struggled to communicate their desire to opt out. In fact, it is common, particularly for certain groups, to be reluctant to state their unwillingness to continue with a project (Alderson, 2004). This can be either due to power dynamics inevitably existing between the researcher and participants, or simply a lack of awareness that they can say no to something to which they have previously agreed. It is interesting to note, however, that the issue of power particularly among participants, can be contradictory. On the one hand, being a participant could be seen as a powerless position, and on the other hand, the very participation in a research study could be seen as a dimension of civil and human rights (e.g., the right to express an opinion, to enter a contract, and to seek social justice). Holding this thought in mind then, by excluding the participant's data, did I take their civil right away and devoice them? If so, as I mentioned previously, it is possible that a parallel process related to devoicing and loss could have occurred, one which mirrored my own experience of feeling de-voiced.

This dilemma has opened up an important debate about autonomy versus vulnerability in qualitative research. Autonomy is concerned with freedom of choice and individuals' abilities to decide for themselves, taking into account their own principles, values, beliefs and perceptions, free of internal and external constraints. The BPS Code of Human Research Ethics (2014) stipulates that respect for the autonomy, privacy and dignity of individuals and communities is one of the underlying principles informing psychological research practice. As a researcher, respect for autonomy means considering all factors that interfere with the decision-making ability of participants, making reasoned judgments about any actions in the research which will impact on the autonomy of participants, and avoiding any procedures which result in long-term impairment or perceived impairment of autonomy. In linking the issue of autonomy to the dilemma, it begs the question, "by withdrawing their data, did I take away this participant's autonomy?"

Beside autonomy, vulnerability is another important issue to consider. Vulnerability refers to the inability to make the best decision to protect one's own interests and can be classified as extrinsic (caused by external issues such as social and cultural problems) or intrinsic (due to internal characteristics of the individual e.g., mental disorders, intellectual deficit, age etc). The issue of vulnerability raises ethical questions about participation in research. To elaborate, it is considered unethical to take advantage of a participant's vulnerability by preventing them from deciding for themselves and including them in a procedure at the wishes of others, or by allowing them to make decisions based on information that has not been clearly communicated to them. The issue of vulnerability forms part of the BPS's well-established ethical principle of justice in research. This principle is concerned with equal share and fairness, avoids exploitation and abuse of participants, and highlights the need to recognise the vulnerability of participants and contributions to the study. Again, in returning to the ethical dilemma, it could be argued that I prevented the participant from deciding for themselves about participating in the research and therefore potentially exploited them.

In conclusion, the biggest challenge during this process was striking a reasoned balance between protecting participants' wellbeing and vulnerability, and recognising and respecting participants' autonomy, agency and capacity. My priority throughout, was to protect and minimise any risk to participants. Looking back, in light of the participant's consent to continue with the study not being explicit, withdrawing them from the study was a way to preserve their psychological wellbeing and dignity. Respecting and putting trust in my participants were prioritised over the research itself.

Chapter 4-Findings

Overview

In this chapter, I present the findings from interviews with therapists on their experiences of working with suicidal students in HE. I discuss each superordinate and subordinate theme in turn and provide supporting evidence for each theme using interview verbatim. Finally, I end the chapter with a brief exploration of process issues which emerged during interviews.

Introduction

The primary aim for this study was to increase understanding of therapists' experiences of working with suicidal students in HE, and I achieved this through conducting semi-structured interviews.

I used IPA to analyse the narratives from the interviews. Wishing to capture the quality of therapists' shared experiences of working with suicidal students, I paid careful attention to personal meanings, language use and metaphors during the analytic process.

Samples illustrating the data analysis process can be found in Appendix 10, 11 and 12.

Superordinate and Subordinate Themes

Following the interpretative analytic process, four superordinate themes emerged (See Table 1). I will now present each theme in an interpretative narrative and use verbatim from interviews as supporting evidence.

Table 1

Superordinate themes and subordinate themes derived from the interviews with therapists

Superordinate themes	Subordinate themes
Theme 1: Exploring suicidality	The phenomenon of suicide
	Assessing suicide risk
	The long-term impact of working with suicide
Theme 2: The context matters	Organisational responses to suicide
	The university 'agenda'
	Universities' expectations of their counselling services
	Uncovering the multi-faceted layers of suicidal distress in universities
	Therapy challenges in HE

SUPERORDINATE THEMES CONT'D	SUBORDINATE THEMES CONT'D
Theme 3: What helps?	Sharing concerns
	Support from others
	Previous experiences of suicide
	Self-care
Theme 4: Barriers to working with suicidality in university counselling services	Working under pressure
	(Too?) Brief model
	Managing suicide risk
	Working and communicating with external services

Exploring suicidality

The phenomenon of suicide. When discussing their work with suicidal students, the majority of therapists discussed the phenomenon of suicide and general societal trends and attitudes towards suicide. Words used to describe suicide included "grim", "bleak", "scary", "haunting", "shocking" and "unbearable". All of the therapists agreed that an inability or

reluctance to talk about suicide existed in society, as Toby explained, “I think, as a society, death is still a taboo, all sorts of death. We don’t talk.” Sue noted that the silencing of suicide was particularly rife in small communities, “people learn from a very early age, to keep it in the house, you don't discuss what goes on in the house outside.”

Some therapists attributed the silencing of suicide to the **shame** associated with suicide. Sue acknowledged that, aside from an inability to talk about suicide, negative perceptions of the act of suicide itself still persisted, “suicide, of course, when it happens, it has a huge impact, but people can be quite dismissive of it and, and it, it can of course be a very selfish act.” Given the negative perceptions surrounding suicide societally, it was unsurprising then that the actual process of exploring suicide with students was challenging for most therapists, as Beth explained, “it is such difficult work…It has been very stressful work....you carry the weight of it.” Beth alluded to **burdensome nature** of working with suicide and this was a theme which was resonated throughout all of the interviews. Sue also acknowledged the complexity of the work, “it feels at times like a really, really difficult…like a difficult tightrope to walk…I suppose at times I just feel I would like more people to know this is actually quite a tough job at times.”

The process of suicide exploration evoked a variety of emotions in therapists. For almost every therapist, **anxiety** was reported as an emotional response to exploring suicidality, as Sue explained, “there is still a great deal of anxiety for me around it. I would be surprised if other counsellors don't experience anxiety. I think it's fairly normal.” Sue appeared to be normalising her own anxiety as a response to suicide and this degree of acceptance of anxiety accompanying work with suicidality was echoed by other therapists. For Nadine, suicide aroused a powerful **primal instinct**, “I think I am a little bit wanting to protect, that motherly instinct…I’d take them all home with me.” [laughs] Nadine’s desire to “take them home” highlighted how unbearable the idea of suicide was for her, and her underlying

anxiety around the topic seemed to be further supported by her anxious laughter. Hannah, on the other hand, although sharing similar feelings, was more explicit in her comments,

> I can't bear the idea of it happening on my watch …I think it's a very hard thing to accept, if somebody's done it, if it's somebody that you know in general or certainly a client…if you were to have that full and frank discussion with them, I'd probably want to say to them however, "Not on my watch…as long as I know you, we will work together to keep you here, you might do that at some point, I really hope you don't but I can understand life is really hard, but it's not going to happen here and it's not going to happen now", that's what I'd want to say.

I considered whether her strong resolve to prevent suicide might be linked to her experience of a previous student suicide, given that her resolve was so palpable during the interview. Perhaps the possibility of a second student suicide was so incomprehensible to her and as a result of this, I wondered about the immense pressure that Hannah may have felt under to avoid a second suicide. In a sense, she was saying that there was no room for error on her part. Her comment also made me consider the degree to which she felt responsible for students' wellbeing, which hinted at an omnipotence, often associated with working with suicidality.

Therapists also acknowledged that suicide exploration was a difficult task due to having to face one's shadow selves and explore the prospect of their own mortality. Hannah noticed the potential for suicidal ideation to impede therapy,

> Sometimes it's (suicide) such an obstacle that you can't work therapeutically with the person because they're not really there. If they were less risky, they would be able to work therapeutically but that's how they manage things, and a lot of times they have very little insight into why they do things. They really shouldn't be in a psychological service because if you can't think psychologically, it's really hard to know what we can do with them, so that's a huge challenge and sometimes that can feel like an incredible burden.

Hannah's comments communicated her despair in working with suicide, and she also alluded to the **dissociative processes** at play in working with suicide as a phenomenon. Interestingly, many therapists referred to an increasing urge to **'do' something** when presented with a suicidal student. Nadine, for example, found herself moving from stillness to action,

> I make myself feel safe by doing stuff like that. If this person phones, make sure they're prioritised. It's a doing thing. Let's put everything in place that we can, to make sure the college know, whatever…so I do all the doing bit, which helps bring things down, and talk about it.

Nadine appeared to be saying that doing something reduced her anxiety, however I was also curious about whether action was a form of dissociation and distracting her from any anxiety. If true, this then highlighted a **parallel process** in the therapy process, in which fragmentation or dissociation was evident in the therapist, as well as the student. Supporting this, Beth recognised that her need to 'do something' served as alarm bells,

> I think when I feel the need to run around, is when I need some time to think what's this about. This is about a defence against anxiety, this is not just because it's very anxious making to sit with this stuff and do I really need to do anything? Is this just to make me feel better, less powerless?

Beth made an important point about the potential for suicide to render individuals **powerless and impotent**. Other therapists alluded to the potential for suicide, due to its' unpredictable nature and uncertainty, to **destabilise** therapists and **increase self-doubt**, as Helen asserted,

> I suppose I may not be the only one who sometimes feels 'am I good enough? Have I got what it takes? Do I need some more training or maybe I'm just getting too bogged down in this work and maybe I can't see the wood for the trees?

Interestingly though, despite the challenges described above in exploring suicidality, every therapist interviewed showed a **willingness to explore suicidality**. Toby expressed his

comfort in talking about suicide, “I feel a willingness to go with people to extreme places.” Sophie, too, shared her ease with this therapeutic endeavour, “I guess I am quite comfortable sitting talking about suicide.” In fact, underlying every therapists’ willingness to explore suicidality, was a recognition of the **value of communicating about suicide**. For Cath, an explicit dialogue about suicide was helpful,

> My experience is that it, it helps people to talk about it……there's something normalising about kind of – it's, it's an expression of the depth of despair and the horrific-ness of the situation. It's not necessarily saying “I'm going to go and kill myself tomorrow”. Then sometimes having that conversation with people, I find, is helpful.

Lastly, Helen highlighted the importance of a suicidal state **being heard**,

> There’s something again about being heard, ‘this person has heard me, they haven’t run away from the fact that I’m talking about possibly killing myself or doing some serious harm to myself’, so I think that comes often as a relief.

Assessing suicide risk. Assessing suicide risk was a fundamental aspect of working with suicidal students. Therapists outlined service expectations to use risk assessment tools, however responses, on the whole, were mixed regarding their usage. Although Helen used risk assessment tools, she did not rely on them solely,

> I do tend to look at them before I see the student, because they’re there and because they have been done before the session, then I do scan them and have a look, but apart from that, even if I’ve got those there and even if the risk there seems to be zero, I do bring it up.

Toby, in contrast, shared his scepticism about the **efficacy of risk assessment tools**, “I didn’t feel the actual form helped me in the room with the person again…I work with it but it’s not, I don’t feel it adds anything to my work. If anything, it gets in the way.” Rejecting risk assessment tools altogether, Cath relied on **intuition or a ‘sixth sense’** alone to help her decipher risk,

> It comes down to this – the, the - a gut feeling, which is suddenly becomes a sort of, you know, therapists would be criticised for sort of – it's a – it starts becoming something else about your intuition or about some kind of counter transference response, what is going on.

It was interesting to note that although Cath referred to countertransference in assessing risk, other therapists did not refer specifically to this. Instead, the majority of therapists spoke more broadly about the importance of **non-verbal communication** in suicide risk assessment. For Nadine, this involved paying attention to the **visceral and embodied process** of the communication of suicide, "You can feel it in the room…. literally……literally feel it." Similarly, Helen hinted at the **implicit communication** of suicide,

> You get a feel of a person, what they bring, and sometimes you could feel that perhaps somebody has a lot of those things in place and yet there is a feel that they are at risk. …….I think it's also these kinds of risks of finding out the kind of more subtle nuances, and there are, sometimes I get a feeling from a person that there is something more.

Toby also spoke to the **implicit nature** of suicide, "If somebody says, talks in detail about their plans, I'll pay attention to that, but it's often what's not said, as opposed to what is said." For Cath, **silence** was a powerful communication about risk,

> Personally, I kind of - if someone's talking to me about it and is able to articulate and is – it, it feels less worrying than, than the times when people aren't and there's just kind of this sense of I don't know what's going on here, I don't – and, and I'm not sure if the student's telling me everything and that can be a very uncomfortable feeling.

Making an interesting observation, Sophie noticed that she assessed risk differently depending on the type of session i.e., one-off assessment vs. ongoing therapy,

> If it's in an assessment, it is more surface because it's more kind of making an assessment, asking questions, whereas if it's someone I'm working with ongoing then it takes a different quality I guess…I think because I know the person more, and

> I kind of know more about how they work and what matters to them and what are the indicators for them, and how they talk about things and what language they might use, because they might not say suicide, they might say something totally different… when I know the person more, I think I can understand more when they're kind of maybe implying it, when you might not in an assessment because you don't know the person…I can pick up on a lot more of the subtleties of what you might not know or understand what they're meaning.

In terms of implications for practice, due to a greater focus on implicit communication, many therapists experienced **heightened attention** when assessing risk**,** as Helen explained,

> I am constantly kind of pinned into, and my sort of senses are heightened and there is that sense that everything is kind of on contact mode, eyes, ears, everything is there kind of picking up anything that comes out.

In a similar vein, Sophie observed a **stillness** when assessing suicide risk,

> It's a particular kind of stillness that I notice myself going into, quite a kind of solid grounded place in order to hold the fragmented-ness of the student I guess, and to really, really listen to what it is they're really trying to say. ……..so the level of attunement, I guess, because of the nature of the potential risk, the level of attention I guess changes, so I might be more open or more kind of picking up more than I might because I'm going so still.

In conclusion, every therapist appeared to have a specific way of assessing risk which was very personal to them, and which served to increase their attention to issues of risk when sitting with a suicidal student.

The long-term impact of working with suicide. Every therapist spoke about the long-term impact of working with suicidal students. Working with an actively suicidal student had a significant effect on Nadine,

> Personally, it stayed with me for a long, long time, because I could imagine it and I'd picture it in my mind, and the picture stayed with me for a long while of that. And it was grim, a grim picture.

Nadine seemed to be emphasising the **insidious and pervasive nature of suicide**. She also acknowledged the extent to which her own mental health had been impacted by the work, "I think sometimes you go home in a low mood or your mood's different and people pick up on it sometimes."

Interestingly, every therapist noted **changes in themselves and/or their professional practice** over the years, due to working with suicidal students. In terms of changes in the self, Hannah observed **changes in her personality**, "I think it's made me a lot quieter as a person." A few therapists, like Sophie however, reported shifts in their **beliefs about suicide** over time, "my ideas of what it means to want to live or die has changed, it's a lot more subtle and complex now than it was." Cath, on the other hand, noticed a change in her **communication around suicide**, "if I'd have fast-forwarded to hear myself talking about talking about suicide or working with suicidal students, I, I kind of – I probably wouldn't have quite believed that I almost sound quite hardened." Other changes in clinical practice included changes in **perceptions of the therapeutic role** in supporting suicidal students, as Sophie shared,

> Somebody described it to me recently…they were in a dark room and they needed me to show them where the door was, and it was their choice whether they went through it or not, but they needed me to show it to them because they couldn't see it, and I guess that's how it's changed now, is that I would feel that it's my job to show them where the door is, it's not about me making them go through it or not, it's like 'that's the door' and so I guess my focus and what is, is different in the sense of 'well I'm sitting in this dark room with you, maybe it's okay for me to show you where the door is, if I can see that and you can't.

On further exploration, Sophie described her the **application of theory to practice had changed over time**,

> I guess my theoretical framework has moved from a theoretical framework to a more working model……you learn about different models of suicide and you read books and you kind of think about it and conceptualise it, it's moved very much from theory into what does it really mean to sit with the student, and to be present in that.

In terms of emotional responses to suicide over time, there was a mixed response, particularly in reference to **anxiety levels**. Whereas three therapists admitted that they experienced less anxiety about working with suicide over time, Sue openly admitted that her anxiety levels had not changed, "I don't think my anxiety has lessened at all about…people who talk about suicide…I don't think it's got any easier over time, to be perfectly honest."

Surprisingly, in spite her increasing levels of anxiety, Sue voiced her **increased willingness to explore suicidality over time, "**maybe more willing to go there……..More confidence to ask questions, not worrying so much about getting it wrong." On the whole, most therapists, like Sue, experienced **greater confidence** in working with suicidal students and engaging with the topic of suicide over time. Nadine observed a **greater trust in her intuition** more over time, **"**it's growing over time. I'm much more confident with it now." Toby, similarly, noted a greater **comfort and confidence** in working with suicide,

> I've always been comfortable with the principle of it, but probably as a practitioner, generally I feel a bit more at ease with myself probably or more trusting. If I feel something, I always go with that whereas before, I might have gone is it okay to go with that?

Lastly, Sophie noticed two opposing aspects of the self over time,

> More confident in the clinical side and the human side, annoyed and frustrated as you can probably tell about the institutional aspect of it, and I guess the more confident I get probably the more frustrated I get with that side, because I feel more kind of, I have more authority to kind of go "don't do it like that".

Interestingly, she made the link that increased confidence led to an authority or desire to challenge institutions about the work context.

In the main, therapists noted mostly positive effects on their clinical practice from working with suicidality over time. One of the key changes was their increased capacity and/or willingness to trust themselves and their intuitive nature which developed over time.

The context matters

Organisational responses to suicide. The organisational context played a central role in therapists' experiences of working with suicidal students. There was a general consensus, amongst therapists, that universities were struggling to engage with the topic of suicide, a struggle which manifested itself, in a multitude of ways. Firstly, the struggle was evident through universities' responses to suicidal students and/ or completed suicides. Sophie identified widespread anxiety within universities, "it's (suicide) something that's quite anxiety-provoking in universities, and I think it's a really interesting subject because it kind of creates ripples throughout the university, and it's often held in that kind of anxiety kind of way." Additionally, Toby noted considerable **fear** in institutions, "it's the personal or institutional fear, that's what conveys itself to me most. That we've got to manage this fear and that isn't my take…my take is, well, we have to accept the fear and bear it." Beth, however, detected a degree of **shame** within universities, particularly in the event of a suicide. She recalled several incidents in which her team received communication about suicides at other universities. Reflecting on the unconscious messages of this communication, she explained,

> There's institutional shame as well. Certainly, whenever there's a suicide, it comes round on the Jiscmail and people in the team, and we get sent a newspaper report that says, XXXXXX had a suicide…I kind of think is this some kind of

> message about “don’t…don’t let anyone shit on the university's doorstep” is actually if I’m honest, is the kind of message I get from it.

According to several therapists, the anxiety and fear reported within universities was predominantly located in academic staff. According to Cath, anxiety and fear stemmed from a **lack of training** in suicide leading to academic staff feeling **ill-equipped**,

> The lecturers are under a lot of pressure and they are very concerned, they're seeing a lot of, you know, they're hearing a lot of things that are very hard for them to hear, because they're not trained in, in the same way that we are and it's very alarming for them…they can see, kind of, evidence of self-harm…that scares a lot of lecturers.

Aside from highlighting training needs, I wondered whether Cath’s comments also pointed to a **lack of ownership** of suicide within institutions. According to most therapists, universities, very clearly, did not want suicide on their doorsteps and often viewed it as something which needed to be expelled from the institution. Highlighting the need for **expulsion of suicide**, Beth reinforced the lack of ownership of suicide within institutions,

> The institution struggles to own the shadow side of stuff, and we see a lot of it with staff, that actually the unhappiness, the institution doesn't own. They have to have the counselling service and that ticks the box, and that means they don't have to really think about it. They’re doing their bit.

The struggle to engage with and take ownership of the topic of suicide was also, to some degree, reflected in the development of a **suicide policy** (or lack of) within institutions. For a few therapists, like Hannah, a lack of clarity around policies existed, “it is kind of a wobbly area, where we don’t always know the policies on it until it happens, like how the institution is going to respond.” Hannah seemed to be implying here that institutions were **reactive** and tended to produce a policy in response to a completed student suicide. Interestingly,

Cath, in stating that a policy did not exist at her institution, made a meaningful connection between **policies and institutional anxiety**,

> It's [suicide policy] lacking and maybe that's one of the reasons I feel that this is really important because it's very much based on kind of individual judgement …….I think, you know, clear policy and procedures don't solve everything, but they are helpful because I think there's something quite anxiety-provoking about it.

Cath was hinting at the fundamental role that policies played in helping therapists feel more contained and grounded in their clinical work. Regardless of this, it was clear that for those who did have a policy in place, there were mixed responses about their use or efficacy. Notably, Beth shared her **scepticism** of the application of policy to practice, "there might be a protocol, but what's the reality…. what is experienced is different to the protocol."

In exploring the impact of institutional responses to suicide on therapists' clinical practice, working in an environment where there were increased levels of anxiety, therapists spoke about the need to **manage their anxiety in the therapy space**, as Beth described,

> Because there's so much fear and anxiety out there in the university, it's like "okay we don't need to bring fear and anxiety into the room, let's keep that at the door" and kind of go "okay what's happening for you here, what's this all about?

Also, working in an environment where there was an institutional reluctance to take ownership of suicide and where the focus remained on expelling suicide, therapists spoke about the increased levels of **responsibility** and **accountability** they experienced in their unique roles of supporting suicidal students in a university setting, as Sue discussed, **"t**o a large extent, it feels as if there is responsibility on me to work…to work with suicidal clients and that, and that often other people, nobody else in the organisation would know." Although there was generally an acceptance of the responsibility for students' welfare, with some therapists feeling **accountable,** not only to the students, but also their institutions, as Beth explained, "we kind of are accountable and we're accountable to our institution."

The university 'agenda'. Almost all of the therapists interviewed made reference to universities' 'agendas' in supporting suicidal students. To elaborate, therapists noted **conflicting agendas** between universities and their counselling services; universities were concerned with **student retention** whereas counselling services focused their attention on **student welfare.** Helen articulated the tension for her resulting from such conflicting agendas, "we're not there just to help the person to develop themselves or stay alive in the case of suicidal students, we're also there to help them complete their degrees, these are subtext." Similarly, Sophie highlighted how the conflicting agendas impacted her work,

> Counsellors would see going through the process of counselling inadvertently means retention improves, whereas a university… sometimes management can sometimes see it as your job is to get them back on the conveyor belt… so yeah I've noticed the conflict there, the retention process, like patch them up and send them on their way kind of thing…There's quite a bit contrast.

Some therapists queried whether **cultural shifts** occurring within universities were responsible for these conflicting agendas, as Cath explained, "there's culture shifts… culture changes within HE, as, as we have, where students have become customers and universities have become businesses and you know, we use words like "operations" and we use business… and we adopt business language." In relation to this cultural shift observed nationally, several therapists spoke about universities' needs, as businesses, to avoid negative publicity at all costs, particularly where a completed student suicide was concerned. Cath, Helen and Sophie agreed that universities' priorities were concerned, first and foremost, with **protecting their reputation**. As Sophie stated,

> I think universities do think a lot about their reputation, and there's quite a lot of reaction "oh gosh is everybody okay, we've got to run around" kind of wanting to hide it, but also fear around it…the focus gets put onto the institution of "How can we protect our reputation and how can we make sure everything's okay?" and somehow the student gets a bit lost in that.

Sophie and other therapists recognised that institutions often placed their own needs above student needs and welfare. As Sophie and Beth both alluded to above, universities prioritised the need to protect their reputation over students' needs at times. For Beth, there was a degree of **self-interest** apparent in universities,

> Institutions are inherently looking after their own interests and he who sups with the Devil needs a long spoon, which is really quite paranoid.' [laughs]….. We do an awful lot of open days. We say how we look after your children and we don't want any of this mess on our doorstep, thank you very much.

Interestingly, Sophie identified that such self-interest led to the **depersonification of a student**, which clearly evoked anger in her,

> I feel for the students really because it's like we're talking about a person here, I get cross actually because when institution voices talk like that, I get angry because it's like actually, we're talking about a person who is really fragile and needs consistency and stability, and I feel annoyed because this person is just becoming de-personified you know, turned into a student number or a 'we don't want it in the papers.

Throughout the interviews, the institutional focus largely centred around their **need to be seen to be doing something** about suicidal students, which included **avoiding or stopping suicide** risk. This was evidenced by Cath's recollection of her institution's response to a suicidal student,

> In the past there, there was a Chinese student, which kind of, there, there was a lot of activity around that, that organisational anxiety that I talk about. There's, there's a lot of things suddenly start happening and kind of ramping up……reputationally obviously it's, you need to be seen to be doing something. It's not good, for any university, I suppose, to be, to be having to announce that kind of thing.

Again, Cath appeared to be referring to the institutional need to protect their reputation and **avoid negative publicity**, which often accompanied a completed suicide. Reflecting on the need to be seen doing something', Beth explored possible underlying motives, "I think it's a

defence against anxiety in part because it is incredibly anxious making. It's a defence against being scapegoated. And it's a defence against powerlessness, and actually, sometimes people kill themselves, there's nothing we can do." Additionally, Beth hinted that, in their need to be seen to be doing something about a suicidal student, universities were often fearful and **wary of refusing support** to suicidal students,

> If I'm being told I can't work with someone and I think that they're at risk, then I will push it. Very often I find that a gap opens up because people don't like putting their names to emails saying that you've got to stop seeing suicidal clients …so actually then the problem tends to go away.

Beth seemed to be implying that institutions refusing to offer a service to suicidal students could also impact negatively on the reputation of the university, especially if a student then went on to complete suicide.

The theme of **blame** also featured largely in therapists' narratives. As Toby acknowledged, the potential for blame within the institution and on the institution from external parties and/ or wider society was increased, following a completed suicide, "I'm aware that with any death, particularly a suicide, there's likely to be a huge amount of anger flying around and that wants to be located somewhere. Whose faultwas it? And it could get blamed on the institution."

The institutional agenda clearly had significant implications for clinical practice. A common thread which ran throughout all of the interviews was that the institution was perceived to be the **third factor** in the therapy room, alongside the therapist and student, as Beth shared, "there's something about being really clear about putting the client in the middle, and all those interlinking factors…….I feel the needs of the institution pressing in, into the room." To avoid any opportunity for blame, Toby focused on **protecting himself and the institution** in the event of a suicide,

> I notice that I not only become more attentive but with a person who's in a particular crisis, not only say likelihood of committing suicide, my notes get fuller and more detailed, more careful. That's partly for a practical value, partly probably a selfish one. If, goodness me, something happens, I've kept the institution and myself safe, which is not very healthy from a therapeutic point of view.

At the very heart of Toby's practice, there appeared to be a need to **justify his actions** and ensure that he had 'dotted the i's and crossed the t's'. Likewise, due to fears of her work being scrutinised or being blamed, Helen shared her **fear of getting it wrong or making mistakes,** particularly with suicidal students, "it's kind of more important that I don't make mistakes or huge mistakes with those students than with some of the others."

Many therapists also reported a degree of **scrutiny** by the institutions themselves, which they accepted as inevitable given the increased levels of responsibility and accountability placed on them by their institutions in supporting suicidal students. Sophie described the institutional scrutiny, in the event of a completed or attempted suicide,

> It feels as if it shifts from a place of "Okay…what's happening therapeutically for the student? What's happening for them? How are you as the practitioner on the receiving end of that process?" …it shifts to "What you have you done? Have you done all the things you should have done? Have you ticked all the boxes? Have you done it properly?" …it becomes more kind of judgmental, I guess…to put a word on it, it becomes more checking up on you.

On the whole, therapists expressed a **discomfort** with this level of scrutiny, or 'checking up', as described by Nadine,

> They'd gone through them (notes) when I wasn't here and checked up. They said, no, your notes are absolutely fine. You did everything properly. You ticked all the boxes sort of thing, done it just as you should have done…but there's a kind of "oh, they're checking up on me" feeling. It was a bit uncomfortable.

In conclusion, I noted a **parallel process** between the therapists' responses and the universities' responses to suicidality: therapists felt they had to 'do' something in order to reduce their anxiety and to protect themselves from feeling incompetent, and likewise, universities' anxieties about student suicide led to them also feeling that they had to 'do' something to protect their reputation. In essence though, both therapists' and universities' concerns were centred around scrutiny and accountability.

Universities' expectations of their counselling services. When exploring the interplay between the academic context and working with suicidal students, every therapist referred to universities' expectations of their counselling services. Due to a lack of ownership of suicide by her institution, suicidal students were seen as something to be expelled from the wider institution. Sophie observed that there appeared to be a general reliance on **university counselling service to deal with crises** and suicidal students were deemed to be the **property** of such services,

> They're wanting to do the duty of care towards the student but it's in a panicky kind of way, in a kind of, almost like wanting the counselling service to rush over 'bring them here, you sort it out' that sort of thing.

Also, therapists' use of language describing the dynamics between the university and its counselling service was telling. i.e. there were anecdotes of suicidal students being "marched to" or "dumped" with counselling services. Again, a lack of ownership or expulsion resonated throughout the interviews.

There was also a **misconception about the role of university counselling services** by the wider institution; some were misconstrued as emergency services offering 24- hour support, as Cath highlighted, "well there's the sort of, that we're perhaps not doing enough, that people would like to have emergency service, you know, that kind of is 24-hours and you know, we, we're, we're not." She also referred to universities' **unrealistic expectations of their counselling services** which included the misconception of the counselling service's

capacity to ‘fix’ everything, “there's a tendency to send people to student wellbeing, send them, send them, send them, send them and that we somehow will be able to kind of magic away their problems.” Cath also seemed to imply that having such unrealistic expectations could create problems further down in the therapy work with students. Reflecting on this further, Beth suggested that universities’ unrealistic expectations of their counselling services might be rooted in an **institutional poor understanding of counselling**,

> I think there is something about working in an institution that might sometimes not have a great understanding of what counselling is, might not have the same set of ethical principles [laughs], and ethical framework that they’re working with. They might be working in a very different kind of paradigm and then they’re coming up against this when we have our own ethical guidelines.

Beth made an important point here about fundamental differences in ethical frameworks, which to some degree, also explained the conflict in agendas as mentioned previously. In light of this, she proposed that the **role of counselling services** was to educate the wider university about counselling, and in this vein, highlighted a common dilemma faced by university counselling services nationally,

> The problem is in institutions, by its’ nature, counselling silences itself. Because it's all confidential [laughs], you can’t go banging on HR’s door going, “Do you realise that we've had six people from Chemistry?”, so we silence ourselves, so it's difficult to advocate, so if we don’t tell people, then how are they to know? I think that’s tricky.

Finally, as a result of the differing expectations outlined above, therapists spoke about a **disconnect** between university counselling service and the wider departments across the institution, and therefore emphasised the need for greater integration across institutions and a joined-up approach institutionally to working with suicidal students.

Uncovering the multi-faceted layers of suicidal distress in universities. The context was also important for therapists in terms of the student population and the

challenges presented by this client group. It is important to preface this section by informing the reader that, when thinking about suicidal students, therapists referred mainly to the traditional perception of the student population, namely those aged 18- 26 years, instead of mature students aged 26 years and over.

In particular, therapists explored possible contributors to suicidality in the student population and there was a general consensus amongst therapists that being a student at university in recent times certainly came with its' **challenges.** Exploring reasons for increasing levels of suicidality in the student population, every therapist cited **a variety of pressures** including academic, parental, peer and financial pressures. Nadine painted a poignant picture of the **multi-faceted nature of pressures** faced by students,

> People getting drunk, people doing all sorts of things, relationship issues, not much life experience yet. A lot of pressure being in an institution, particularly like this. Peer pressure, competitiveness. Families are often quite dysfunctional. A lot of pressure from families sometimes…I think that things can change very radically for them very quickly, whether it's in their friendship groups, their academic work, their families…there's just an unusual amount of pressure in a very short period of time.

Nadine seemed to be suggesting that students were unique in terms of the multiple pressures they were having to navigate in comparison with their non-student counterparts.

Referring to 18-26-year old population, there was also an acceptance amongst therapists that suicidal feelings were synonymous with **early adulthood**, as evidenced by Sue who associated suicidal ideation with **youth and lack of life experience**,

> It doesn't surprise me that young people would be considering suicide, almost as if it's part of that age perhaps…of exploring that…It doesn't seem unreasonable for me for a young person to, to consider it…at that age, it's much less clear and I think you're trying out different aspects of yourself…"what fits and what doesn't?" and

> you know, “how much am I like this person or these people, am I not, who are in my peer group” and considering, “am I somebody who might take my own life?”

As Sue and others alluded to, the university years represented a period of **identity exploration** for many students.

Therapists also attributed increases in suicidal distress in students to the **current context**, as portrayed by Sophie,

> I think there’s more pressure, I think there’s more instability, I think students have a lot more things to be bothered about than they used to…Students talk about “Do I want to be here in the world as it is?”….the world is so difficult and complicated and there’s so many, at the moment…it’s chaos going on…so it’s not surprising that they’re questioning those kind of things, like “Why would I want to bother being here?” It’s not easy.

Similarly, Cath considered the **political climate** and its’ impact on student mental health,

> They've grown up with this is the backdrop….this country is in a bit of a mess..…….the number of people who were coming in sobbing, you know, young students as well, about Donald Trump and about Brexit and just a real, you know, the kind of environment that we're in, a, a real despairing oh my God, kind of anti-capitalist…and I suppose, you know, whilst we're seeing students and all of these things are going on, politically and, and my own sense of kind of “Oh my God, oh my God. What sort of world are we in?” Quite an increasing number of students who were saying I hate… I'm not on Facebook anymore and I've deleted my account. I hate Twitter and not listening to the news anymore and it's quite dark at the moment.

Many therapists engaged in wider discussion that centred on students’ **foci on external worlds**, symptomatic of the societal obsession with the ‘selfie’ culture, as Beth explained, “it’s the whole…”what is my identity, my existence?” gets put on performance, it’s all about

"how am I appearing in the world?", so little time and attention is put on the inside of the person." Hannah echoed this sentiment in exploring the role of **social media**, "it just seems like there's this constant feed of stuff rather than people really relating to what's going on inside of them." Although social media was developed as a means to connect people, for some therapists, it also played a large part in isolating students further from their peers leading to **loneliness**. And for Toby, **isolation** was a key factor which contributed to increased suicidality in students, "it seems to me, feeling isolated and unconnected is a huge part of what contributes to suicide." Most therapists identified isolation as a pertinent theme particularly amongst **international students** who were considered a concerning subset of the student population in regard to suicidality, as Nadine highlighted,

> Sometimes particularly the overseas students, very vulnerable. They're away from home, new environment, not familiar with the culture, all very strange. "Don't know anybody, don't know how to get to know people" …I think with the overseas students, there's the "I can't take my own life, I would but I can't. There's so much invested in me and it would bring shame on the family".

Moreover, **unrealistic expectations** amongst the student population were identified as contributors to suicidal distress in students. Beth, below, questioned the role that institutions played in shaping students' expectations,

> They (students) have this very narrow view of what success is, "If I don't get a first or a high 2:1, then four years are wasted, and I'll never get a job"…..so you get this very binary thinking…I do feel that the universities are complicit in this. The system, they like having the A's and A stars, and being able to cream off their little fraction of the student population that they know that that's their bit because it's all the market… and "we want them all to be winners. We're educating winners here." What happens to those who occasionally lose? It's such a binary, you succeed, or you fail.

Interestingly, on this point, the theme of blame re-emerged, and again, blame was directed towards universities by therapists such as Sophie, who asserted that universities were culpable for **creating competitive environments**,

> I guess that the environment of university has become like that, I think that's what's scary, it's scary that we're creating an environment in which people are kind of not wanting to be alive, it's like "what's that about, why are we doing that to people, why are we putting so much pressure on a young person?"

When discussing the role of universities, for Sophie and Beth in particular, there appeared to be an underlying degree of anger towards universities and a sense that enough was not being done by universities to support students around their mental health.

Therapy challenges in HE. When considering the context, every therapist also spoke about specific challenges they encountered when working therapeutically with suicidal students. For a few therapists, the academic structure was disruptive to the therapy process. Toby, for example, demonstrated the detrimental effects of a **transient lifestyle** characteristic of the student population, had on the therapy process,

> Sometimes clients or people don't want to engage, or it gets disrupted because they go away for term, a term break and they don't come back….so there's that...Students often are here for a term and go back home for the holidays, which means the therapy or counselling is discontinuous.

For other therapists, like Sophie, the contextual constraints impacted **perceptions of suicidal students,** "because we're a pressurised service…they're perceived as difficult clients. I think that can be an issue."

Suicidal students**,** themselves, also presented challenges in the therapy work. Aside from needing considerable support from a university counselling service in terms of time and resources in comparison to their non-suicidal counterparts, they were also considered difficult due to their **impulsivity**, as suggested by Nadine, "somebody could just say

something rude to them and that would tip them off or anything out there. Or something nice could happen and tip them." Additionally, recalling a previous encounter with a suicidal student, Cath stressed the **unpredictability** of suicide amongst students, "she really affected me, because that, that felt so real and there was something about the sort of small overdose, but multiple and, and it was almost sort of roulette that it might – one day she might." In equating her student's suicide attempts to playing 'Roulette', she appeared to be bringing to light underlying feelings of **powerlessness**. Moreover, the **rapidly changing nature of suicidality in younger people** presented difficulties for Nadine when assessing risk, "you know what they feel in the room with you, they might feel very different in a few hours' time when they're all on their own."

Another area of concern for several therapists were **suicidal students who were unwilling to use counselling services.** Possible reasons for not accessing the service included a **fear of disclosure impacting their studies** as Hannah suggested**,** "if they've just walked in, they might not indicate risk because they don't want it flagged up…it might put them off their course or that's their feeling or their fear." Equally, Helen suspected that students' reluctance to seek support might be linked to a **fear of discrimination**, "some of them are reluctant to declare them because they fear that they would be counted against them instead of actually them being able to get some support."

Despite the challenges noted above, there was an **air of optimism** among most therapists in working with suicidal students, as Helen attested to,

> My sense is that suicidal students are amenable, a lot of them are amenable to counselling and to being a student, and that as counsellors we can work with suicidal students and can help them to help themselves quite a lot.

Finally, Toby recognised how study could help bring about change in therapy, "I love working with students because there is often a great capacity for change. Very often, if there have

been childhood issues, it's the first time living away from home…so there's an opportunity to explore things."

What helps?

Sharing concerns. The majority of therapists agreed that **sharing concerns** about working with suicide risk with others helped in their work, particularly in light of the anxiety surrounding the work. Nadine justified her need to share concerns,

> It's another pair of eyes, isn't it?...another pair of ears… another perspective on things, at least one other perspective on how you see things. Because when you're particularly upset by something or you're not seeing something straight. I think your threat system's activated, your perspective can narrow, can't it? I think that's really important, those times when you feel that you're under threat.

In her comment above, Nadine recognised the capacity for suicide to de-stabilise her, threaten her equilibrium and negatively impact her decision-making process. This was a common experience shared by many therapists who, in their own ways, subscribed to the idea that holding suicide by oneself seemed untenable. Helen found that sharing concerns was a source of **validation and reassurance** for her, "it's somebody saying, 'yeah you've done what you can', it's that person and hearing, and the colleagues and the team saying, 'yeah, none of us would have done anymore, we agree you've done what was needed."

Another crucial aspect of sharing concerns with others involved the **transfer or passing on of information**. For Nadine, there was a **safety in informing others**, particularly when working with impulsive suicidal students, "these impulsive ones are just as risky, because they could do something impulsive that they don't think is going to end up in death really…yeah…I usually, quickly, get lots of other people involved, and other people knowing about it." Again, what Nadine appeared to be hinting at was that in sharing concerns about

risk, there was also a **sharing (**or unburdening perhaps?**) of anxiety**. Furthermore, sharing concerns with others did not only include immediate colleagues, but also those working in statutory services. Sharing information with the NHS, for example, was comforting to Cath,

> I felt that I, I needed to kind of formally, in a way, kind of transfer her. You know, I felt like I knew stuff that, that wasn't captured anywhere … it felt like it would have been a missing piece of a quite important, sort of, piece of jigsaw for them [GP] not to know about something.

Support from others. In terms of support, the majority of therapists tended to seek out support from their peers/colleagues rather than line managers or senior management. Given that working with suicide could feel isolating for therapists at times, almost every therapist found that receiving support from their colleagues aided their work with suicidal students. Hannah highlighted the benefits of **collaborative team**,

> We're a very supportive team of each other, so I think that's really helpful and to be able to...we consult with each other a lot…having that kind of collaboration, whether it's debriefing later, whether it's actually going and finding somebody, that can happen more on a duty day, where somebody's brought in or they arrive in a state, or they're in the emergency appointment slot and you're not quite sure, so having a collaborative team is really helpful.

Aside from peer support, the majority of therapists also recognised the value of **supervision** as a facilitator in their work with suicidal students. Cath spoke highly of her supervisor, "I have a fantastic supervisor, which is really, really important and, and I can – if I, if I need, if I need to talk, often I will go to her." Beth, too, described the benefits of supervision when working with suicidal students,

> She (supervisor) really gets it…so when I'm talking about it, she doesn't panic. She's just very calm, because if you're containing the client and then you're talking, the last thing you need is your supervisor to panic…What you need is a supervisor

> who will be calm and measured…So it's always something I look for if I'm looking for a supervisor, is the attitude towards suicide, how they would respond. So that's what I ask, because I need to feel the wall at my back.

Beth appeared to be implying the **containing and holding role** of supervision when working with suicidality, and highlighted the importance of having such support, against the anxiety-ridden backdrop of the academic context,

> There might be other people who are anxious and maybe other people who, there might be some scapegoating around…there might not be. But somebody who's solid enough to hold that and keep that out of the room, for me…so it's almost like a parallel process. I work really hard to keep it (anxiety) out of the room for my client and I need a supervisor who will do that for me…I think, if I didn't have a good supervisor or trust and a team of several people I really trust, it would be much, much harder work, much more anxious making work.

Beth made a very important point about another **parallel process,** which occurred for her when working with suicide. For Beth and other therapists, it was apparent that having a supportive colleagues and supervisor allowed therapists to feel more grounded and contained, qualities which therapists deemed essential in order to support suicidal students.

Previous experience of suicide. Previous experience of suicide (personal and/or professional) was also considered to be facilitative in therapists' work with suicidal students. Over half of the therapists disclosed a **personal experience of suicide**; this included a personal history of suicidal ideation or suicide attempts or family members/ friends' suicide attempts or completed suicides. On the whole, therapists' personal experiences of suicide changed their relationship to suicide by **increasing their awareness** of suicide and leading to a **greater acceptance of suicide**. For Sue, a family narrative brought suicide into her **consciousness**,

> There was a, there was a story in our family that someone had walked into the sea with, with stones in their pockets and she drowned. She killed herself very

> deliberately, she was so unhappy, and I think when you have a story in that family, in your family, I actually think the possibility is not so shocking. It's almost like somebody else has done this in our family, so I could do that too.

Elaborating on how this experience impacted her clinical practice with suicidal students, Sue added, “I feel I've got a little bit of understanding…I absolutely would never dismiss anybody in any way whatsoever, because I absolutely know that I have felt like that and I know that people do.” Having disclosed a family member’s suicide attempt, Helen too, agreed that her own personal experience **made suicide a reality** for her, “I know that it’s real, people do do these things and it has to be dealt with.” Cath’s previous history, of being brought up in an environment where a family member’s suicidality was not discussed, increased her willingness to engage in an open dialogue about suicide with her students, “my view is that it's almost quite healthy to talk about it…it informs the way that I am, and I think that I encourage students to.”

Some therapists also reflected on their **professional experiences of suicide**; these included either completed suicides or suicide attempts of students on their caseloads or within the wider university. By way of a summary, one therapist reported a completed student suicide on their caseload, one therapist reported the suicide of a non-service user, and three therapists referred to multiple students on their caseloads attempting suicide during their work together. All of these therapists highlighted the profound impact of the attempted or completed suicides, albeit in different ways. On a touching note, Hannah shared her poignant reaction to a completed student suicide on her caseload,

> Certainly after it happened I was much...I remember telling my supervisor, particularly with boys, that I wanted to just chain them all to my radiator so I could keep an eye on them, because it was just terrifying…and I probably offered, in that semester, I probably offered a lot of them a lot more sessions than I normally would considering what they’re presenting for.

It is clear from Hannah's comments above that her anxiety post-suicide resulted in hypervigilance and over-compensating behaviour. She also highlighted how her **relationship to suicide changed** following the suicide, "risk is a concern anyway, it was even more, that really brought it to the forefront for me…It's something that's close to my heart and it was before losing a client, but certainly even more so since."

Lastly, **significant long-term changes in her clinical practice** also occurred as a result of the completed suicide,

> I think it makes me more vigilant…and it can be vigilant in all sorts of ways whether it's looking out for people who are at risk in some way or at risk to others…I think it's made…the risk assessment has been more integral to my practice.

Self-care. The general consensus, amongst all therapists, was that good self-care was crucial in order to support suicidal students, although therapists varied in their self-care strategies. Achieving a healthy work/ life balance was frequently mentioned in terms of self-care and this was achieved through a variety of means. Some referred to **personal self-care strategies** used to improve their wellbeing. Helen, for example, recognised that **solitary time** was important for her, "there are times when I do need time by myself, I wouldn't sort of want to be in company, need to kind of have a bit of me-time.''
On the whole, though, almost every therapist stressed the **importance of close, supportive relationships**. Cath cited her husband as a source of support, "I will talk to my husband, because sometimes if I go home and I'm carrying something and I'm not talking about names and specifics, obviously, but, but I, but I, but I do get support from him." Therapists also replenished their bodies through a variety of activities such as sleeping, eating, walking, meditation, religion, taking care of pets and reading. The majority of therapists also used some form of exercise as a part of their self-care. Sophie reflected on the power of **dance** to help improve her wellbeing,

> I find that things get held in my body, I might have let it go on a conceptual level in the field, but for me personally it's more likely to get held in my body and I might not even notice it until I move, and then it's like, oh that's better, that's gone away now.

Acknowledging the powerful somatic effect of suicide, therapists spoke about the need to **'switch off'** from the stresses of therapeutic work. For Cath, having **variety in her life** helped,

> I need space to do something different, to get out and go for a run…Do a lot of exercise and to read, read books and to just be in the fresh air and, and do something completely different than being in a room with somebody.

Hannah discovered that **being in a contrasting space,** both physically and emotionally helped, "being in an environment that has absolutely nothing to do with this kind of work you know, people from all walks of life who have allotments, just kind of reminding you of what's normal, what's good."

Other therapists identified **workplace strategies** to improve self-care. The majority of therapists realised that **accepting the risk of suicide as an occupational hazard** was important. As Toby stated,

> It seems to me as a practitioner, that's part of the job, to live with that risk….while one wants to do everything one can to minimise it or to work through things so they're not at risk of doing that, risk it seems to me, to be part of the job.

For Cath, **accepting her own powerlessness** was key in working with suicide,

> It is sometimes about managing your own anxiety and, and sitting with the uncomfortable feeling, that I said right at the beginning, that we can't, we can't get rid of that, because we're dealing with humans and people are impulsive sometimes and, and they won't tell you the whole story, however, open you, you are or try to be or you know, and sometimes they can't say it.

Beth, on the other hand, acknowledged the importance of **creating firm boundaries through compartmentalisation** in order to cope with the stresses of working with suicidal

students, “there is something about compartmentalising feeling really important, so I can be completely present in this compartment, but then the door has to be shut when I leave.” Cath recognised that **humour**, although a form of defence against anxiety, had helped her in the past,

> People will joke, and you know, meet – use humour and, and actually what we're talking about is horrific, but it's a way of protecting sometimes and I suppose we, we do that with colleagues. Sometimes we, we – it's all quite upbeat and when we're in a private space, which doesn't happen that often, but certainly in sort of supervision or whatever, sometimes people would be quite inappropriate and you think “my God, if people heard this”, but I suppose it's, it's a way of dealing with it.

Finally, some therapists considered **practical strategies** to limit the stress from working with suicidal students. For example, Cath found that **reducing her working hours** helped her achieve a healthier work/ life balance, “I work part-time on – I don't know how my colleagues cope who work full-time doing it, five days a week, five clients a day.” Beth, on the other hand, re-structured her **work schedule** to allow more **space for reflection**,

> If I’m working with someone who is actively suicidal, I don’t stick them right at the end of the day. I stick them in a place in my diary where I know there will be space for me to think before I go home, so it's not the last thing I do because I work part-time…So there's something about processing it in the day so that symbolically I can leave it here…so I might think about it at home, but it doesn’t preoccupy me.

Although all of the therapists used a variety of self-care strategies, the strategies shared certain common features. The key purposes of self-care strategies were to **protect oneself** from the effects of suicide and achieve a **degree of detachment** from the work. There was also an underlying need for safety amongst therapists, as Sue described, “I go to bed and I read, go to bed and watch the telly. It feels like a safe place for me to be in my bed.” For me, this comment really brought to home the potency of the phenomenon of suicide and its potential somnolent effect on practitioners.

Barriers to working with suicidality in university counselling services

Working under pressure. There was a unanimous agreement amongst therapists that university counselling services were akin to 'pressure-cooker' environments due to **significant increases in referrals** witnessed in recent years, as Cath explained,

> There are more people coming in with kind of mental health problems, with more complex conditions and all of that kind of thing and everyone's under a lot of pressure and it's just feeling a bit like that. It feels quite different to five years ago when I first came in.

Aside from increasing number of referrals, the pressure, for Cath, also emanated from the extent to which suicidality was in the ether of a university counselling service,

> You are hearing and thinking about it (suicide) almost every day, in some context or another, not necessarily with your own students, but with someone else's, but it's constantly a theme. Whether it's on the jiscmail or something – you know, something's, there's always something in a magazine or professionally, that it's there all the time, in a way that it's not in most other people's lives perhaps, apart from people who are struggling with those thoughts themselves.

Cath appeared to be highlighting the uniqueness of the context, and yet the **perpetual nature of suicide** was a theme echoed by many of the therapists interviewed, and for some, this context resulted in changes in how they worked. With an increase in overall referrals, **longer waiting lists** placed greater **pressure on therapists to work quickly**, as Sophie explained, "there is a kind of "work as short as possible because we've got the pressure of the waiting list", so although we can work as long as they need, there's a kind of pressure to turnover." Cath, on the other hand, expressed her **fear of missing something** as a result of the high-pressured environment, "I suppose on a bad day if you're feeling very busy, you can kind of worry that if you're missing things like that, might you be missing something that's more important." She also recognised the detrimental impact of a busy environment and how this could impact and compromise her practice, "that's not how you pick up or not how I pick up what's going on for the other person." It was clear from her comments, that

Cath was apprehensive about working in a pressured environment, leading to her **questioning the accuracy of her assessment skills** when working with suicidal students.

Additionally, Beth explained how **service pressures impacted her decision-making** around her clinical practice with suicidal students,

> Because as a service we're under such pressure, there's a constant sense that we've got to balance the needs of that person and trying to help that person feel safe and work on their issues against the needs of the waiting list, the pressures on the service. The fact we're supposed to be kind of focused, marginally short-term intervention and that somehow the individual counsellor is left to square that circle or circle that square, or whichever way you do it. Somehow that, so if you can't make it right, sometimes I feel when I'm under pressure, that the implication is either "I'm not a very good counsellor" or "they're not a very good client", because if that makes sense...I think that's to do with the individualising of the pressure of the waiting list and work.

Beth highlighted above the double bind that therapists were often faced with, when trying to manage the pressures created by contextual constraints. In particular, she alluded to how working with suicide could lead to an **individualising** process, in which individuals were singled out or left feeling isolated in dealing with the pressures placed on them by their institutions. Cath also pointed to this **isolation,** resulting from working under pressure,

> Ultimately most of the time, it's all so fast-moving, you're kind of on your own with that or it feels like you are, so it's hard when, when there's not, I don't know if that answers the question, when there's, there's not quite so much ability to, to kind of check things out…it's just people have less time to give and a visible sense of that, of people kind of rushing around and kind of doing, having to take care of themselves I suppose.

In conclusion, working under pressure appeared to create a vicious circle for most therapists; increased number of appointments led to reduced contact with peers and therefore less support, which in turn led to increased anxiety and feelings of isolation.

(Too?) Brief Model. Aside from the pressure resulting from increased demands, the length of counselling contracts offered to suicidal students was another area of concern for all therapists. Every therapist spoke about institutional pressure to adhere to a **brief therapy** framework and most voiced their dissatisfaction and frustration with using this model, as reflected in Helen's comments,

> I think, organisationally, the greatest problem these days is the need for brief work, I mean the ethos is, now scarce resources have to be spread as far as possible, six sessions, four if at all possible, and you think "my God, well I've got this suicidal student and I'm supposed to help them in six sessions or four sessions or whatever it might be, to somehow deal with this really, really difficult issue".

The implication here was that the task at hand was an impossible one, given the level of difficulty presented by suicidal students and that six sessions was simply not enough to meet students' needs. On the whole, most therapists felt **constrained** by institutional expectations to offer brief therapy to suicidal students. Beth questioned the underlying motives of institutions in regard to using a brief model,

> I'm just conscious of feeling irritated, thinking well, "what is the message here?" The message is, "Keep everyone safe, but do it on as few sessions as you can, and if you can't, then either you're not a very good counsellor or they're not a very good client". It's like you're trying to tidy up the mess of life and that's just…That's not going to work, is it? It's nobody's fault if it doesn't work, it's a rationing issue you've decided on……..And if some people's needs aren't met because there aren't the resources, it doesn't mean their needs aren't valid, and it doesn't mean that the counsellors are not working as well as they can do within the constraints.

She went on to highlight that a lack of transparency existed around the **rationing of resources** and considered how limited resources had serious implications for the wider institution and their management of suicidal students,

> It is an institutional responsibility. We take these people in, we take their fees and we say we provide a counselling service and if we're not prepared to support them, then I think the institution needs to own that and that it's a rationing issue. It's not to do with what the client needs, it's a rationing issue because resources are scarce.

For some therapists, using a brief model led to **changes in their roles** in supporting suicidal students. Helen articulated this change as,

> The role changes yes, from a counselling role to more a kind of reviewing and monitoring and periodic meetings…What you might also do in some instances is make the six sessions then take place periodically, so we might not meet every week, so we might meet fortnightly or spread it out even more, which then becomes more monitoring rather than counselling, it becomes something that you're kind of touching base, you're reviewing.

For some therapists, this role change was a frustrating one, as Hannah comments implied, "we're not trained to only monitor risk, and sometimes it can feel that way a bit."

When discussing the brief framework, some therapists also reported feeling **powerless** in making decisions about treatment planning for suicidal students, particularly when it came to extending contract lengths. Helen highlighted the potential for a 'mismatching' between service and students' needs by offering a '**fit all' service**,

> That assessment might say 'well actually this person would benefit from slightly longer-term work' or 'this person would benefit from this, this and this' and yet what I can offer tends to be something that is supposed to fit all, and yet it doesn't.

Finally, using a brief model to work with suicidality created **internal conflict** for some therapists. Using a brief model where time was of the essence clearly conflicted with Beth's

ethos of therapy practice, as she explained, “I need to have that freedom where I’m not thinking about the end in amongst it all.”

Managing suicide risk. Another aspect of working in a university counselling service which created obstacles for therapists to navigate, came from the management of suicide risk within their respective services. Where therapists’ experiences of management of suicide risk (i.e. service managers) were concerned, responses were mixed. A few therapists, like Nadine, reported having **positive and supportive relationships** with their managers, “my personal line manager would come up probably and check in with me if I haven'tchecked in with her. It’s very good, very supportive.” Conversely, Beth experienced a **lack of consistent managerial boundaries,** which served as a major hinderance in her work with suicidal students. When asked to elaborate on her experience of a lack of consistent managerial boundaries in the workplace, she commented, “yes, that’s [lack of consistent managerial boundaries] a big issue. Yeah, it is my biggest single issue, I’d say, working with suicidal…which is a shame, because actually, the single biggest issue should be the client.” Similarly, Sophie observed a **lack of holding of clinical responsibility and risk** within her service,

> In reality, the sense of the holding of the risk doesn't always work, it gets put back onto...there can be either a bit of a knee jerk reaction where the manager kind of grabs hold of it and whisks it off …or a blaséness…Although they might officially hold it, the clinical responsibility can get pushed back…People don’t particularly feel held with the clinical, the risk responsibility, and that is kind of put back onto the individuals really.

Expanding on this, Beth considered whether some **ambivalence** around holding clinical responsibility might exist amongst managers,

> I think they want the problem to go away, but they don’t want to own the responsibility of the risk, and that's not everybody and that's not every manager, but there are some managers who don’t want to own the responsibility of the risk. But

> they want the problem to not be there.

Some therapists noted the detrimental effects that ineffective management of suicidal risk had on counselling teams as a whole. Sophie noticed that a lack of confidence in management had serious implications for communication within her team. For example, she noted that therapists tended to talk to supervisors and colleagues rather than managers, resulting in a **fragmentation** or **splitting in the sharing of information** around risk concerns,

> In this team, it means that colleagues will talk to each other a lot more about it than they would to management; they're more likely to...not as much really, so it'll be like held "out there"…that's what it was like at the previous university as well, that it was held with supervisors and colleagues because you knew that if you took it to management, there would be such a weird reaction to it, they'd either be "have you watched your back enough and have you ticked all the boxes?" or they'll kind of grab it under their arm and run off with it somewhere to anxiety land.

I was struck by Sophie's description of two polarised management responses to risk. In many ways, such polarities again mirrored the fragmentation and splitting associated with suicide. Nevertheless, most therapists emphasised that a **lack of integration** could have disastrous effects for the management of suicide risk, including the holding of crucial information about suicide risk. Helen also clearly highlighted the need for **clarity around reporting lines**,

> I need to know where I'd go with things, what my reporting line is as it were…it gets very difficult if somebody doesn't know when they should report something or who is ultimately holding the risk, what the procedures are. I think it makes it even more difficult, and it makes the pressure and the stress harder…t's going to burst out somewhere before too long, that's my fear.

Helen appeared to be implying that clarity around managerial clinical responsibility had an

extremely important **containing effect** on therapists and reduced anxiety levels around what was already known to be anxiety-provoking topic.

Although therapists differed in their attitudes towards managers, every therapist, nevertheless, stressed the importance of **management support in feeling 'held'**, when working therapeutically with suicidal students. As Sophie stated, "it matters to me to feel supported by management, that I can kind of be clinically held." In appreciating the pressures that managers faced, Sophie noted managers' **duality of roles** in managing suicide risk,

> It feels like they're sitting in this double thing, facing inwards and outwards at the same time, and they don't always seem to know what to do, and I don't think it's an easy place to sit because they've got the pressure of the university on their back but they're also trying to hold a clinical responsibility for the client work, so they've got a kind of double role really.

On a final note, I noticed **considerable anxiety** when therapists were discussing experiences of their managers in relation to working with suicidal students. This anxiety manifested itself in several ways: some needed reassurance about confidentiality before divulging, whereas other lowered their voices. Some therapists also showed some hesitation before answering while others became more aware of the audio recorder and/or the interview space itself.

Working and communicating with external services. Working with external services played a significant part in therapists' experiences of crisis management with suicidal students. It was an area of increasing interest for therapists, partly due to limited resources in universities but also partly due to **uncertainties about the future of counselling services** nationally, as Sue confirmed, "we see counselling services all over the place being closed." Moreover, in light of increasing demands and brief counselling contracts in universities, there was a degree of inevitability, amongst therapists, that suicidal

students would need an onward referral to an external service who might better suit their needs. The dilemma, therefore, for most therapists, appeared to be **where to refer suicidal students** on to for further support, as Sophie stated, “because we're time-limited, there's a pressure to get them seen somewhere else or held or to move the risk away from the university to somewhere else, but there’s not always anywhere else for it to go.” Sophie’s comments hinted at the challenges of making onward referrals and the quandary that therapists find themselves in, often leading to feelings of **hopelessness** in regard to a student’s treatment plan.

In the main, most therapists referred suicidal students to the National Health Service (NHS). When discussing their experiences of external services, the NHS, in most therapists’ eyes, was perceived to be struggling with increased demands on their services and because of this, therapists often witnessed suicidal students “**bouncing back and forth” between NHS and university counselling services**. Sophie shared her experience of making referrals to the NHS,

> They thought it wasn’t quite enough for whatever criteria they had for it to be held there, so it was kind of bouncing back and forth and I’ve had that quite a number of times actually, bouncing back and forth between the NHS and the university, it’s not very helpful because if they’re a student they just need to be held in one place in a really containing way, and they find themselves being kind of bounced back from one place to another, so I find that frustrating.

Clearly, this process of bouncing back and forth resulted in **frustration** for therapists like Sophie, however it also led to instability amongst suicidal students. Sophie articulated the negative impact of making such referrals to external services, “the needs of the student get lost and it all becomes about kind of trying to move the risk on rather than what does this person need?” Sophie seemed to be intimating that the focus on wanting to move suicidal students on to external services meant that suicidal students’ needs were being overlooked and neglected. Therapists also highlighted that the ‘bouncing back and forth’ between

services was due to limited **cut-off thresholds** held by statutory services, leading to **greater pressure** being placed back on to universities to support suicidal students, as Hannah stated,

> Once somebody's come through the door we're expected to monitor it, and just because you know, if a person either won't engage with their GP surgery, or often times there's nowhere really for them to be, the home treatment team does certain things, the crisis team does certain things, our students don't always meet the criteria and either way, they're always trying to discharge them to us again.

Interestingly. as a result of limited onward referral sources, Hannah noted that her **role changed**, "what is very hindering is that services are so overstretched, and we do sometimes feel as if we're monitoring risk rather than doing therapeutic work." She seemed to be implying that with pressure put back on university counselling services to support suicidal students, her role became one of holding suicidal students, rather than actually doing therapy.

Although the majority of discussions on working with external services centred around the NHS rather than voluntary services, similar views around limited resources were expressed in relation to the voluntary sector. And yet, although working with external services was challenging and frustrating, liaison with the NHS about suicidal students also provided some degree of **security** for many therapists, as Hannah suggested,

> There was something about a sense of security about knowing that I am highlighting that this person has said something or done something or told me something, that is of concern and that that's not just lost in the ether, that there's a GP who, who has kind of responsibility for that person's care, that they, that they get to – they, they know that.

Also, Hannah highlighted the need for **good communication** between services and how this can impact therapy outcomes, "the more joined up people are, the better things go for the client."

Finally, external services were perceived to offer some degree of security, and in being unable to access such services, there was a lack of safety reported amongst therapists and students alike. The instability noted in working with external services impacted, not only the role of therapists working in HE, but also the students themselves. Again, the findings highlighted that a parallel process of fragmentation was evident, not only in students, therapists, and universities, but also external services involved in suicidal students' care plans.

To conclude, a recurrent thread across all of the barriers emerged, one which related to communication and the experience of voicelessness. Therapists alluded to not having a voice in relation to managing caseloads and/or new referrals, the brief model contract, managing risk and working with other services. There was a prevailing sense of powerlessness and feeling silenced among therapists. For some, there appeared to be a desire to reclaim their voice as a therapist when working with suicidal students. In many ways, a degree of censorship and de-voicing emerged, and a parallel process related to voicelessness was evident at three different levels i.e. in therapists, universities and the researcher.

Process Issues

I will now briefly discuss the process issues which emerged from the interviews. **Anxiety** was evident in most interviews and was manifested through displays of caution, hesitation, stuttering or difficulty in articulating thoughts/feelings at certain points of the interviews. Anxiety also manifested itself through **use of humour** in the interviews. I noticed that some therapists either joked or exhibited nervous laughter, perhaps to defend against any anxiety. For other therapists, **seeking reassurance** about confidentiality during the interview pointed to some underlying anxiety, as Beth stated, "yeah….so sometimes it's

okay and other times it's not, and it feels a bit whimsical. This is reasonably confidential, isn't it?"

Some therapists also appeared to experience a degree of **dissociation** in the interviews, illustrating the unconscious processes evoked by the phenomenon of suicide. Dissociation revealed itself in numerous ways. To illustrate this, when therapists were asked to identify and name the feelings evoked when confronted with an actively suicidal student, some therapists struggled to articulate their feelings. In some cases, therapists spoke about suicide in a **detached manner** (i.e., speaking in the third person) or they **failed to answer the question**. It also manifested itself in the form of **memory loss** about suicidal students or the interview questions, as Nadine explained, "funny, because there was somebody this week, last week, who… funny, this person didn't come to mind at all when you first talked about this. Strange, isn't it?"

I also noted some therapists' use of **powerful visual imagery and metaphors** to describe their work with suicidal students. Unsurprisingly, the language used was often associated with life and death, as Beth noted,

> I've got all my lifebelts and this and that, emergency oxygen, or whatever. It's all out of the room. It's all there, it's all out of the room and I'm in the room, and this is just what we're doing together, and I can put everything else out of my mind, and I just be myself.

Therapists' **feedback** about participating in interviews were also very illuminating. On the whole, almost every therapist explained that the interview had given them a **valuable insight** into their work with suicidal students, and **validated their work**, as Beth explained, "it's actually been very validating speaking to you, because I think sometimes, for all that I've taken to supervision again and again, I think talking to you, I'm really, really clear about my

confidentiality, the importance of confidentiality." The interview also allowed some therapists, like Beth, **t**o **identify areas for further reflection**,

> I think I'll reflect on my lack of trust in the institution's ability to contain this stuff, the management line's ability. And I think it's not that they can't as a whole, but that it's inconsistent… that some can, and some can't.

For others, having space to reflect in the interview actually highlighted **the lack of space for active reflection** in their usual daily work schedules, as Toby pointed out, "it's been interesting for me because I haven't actively taken time to reflect on my practice. These things have been in the background a bit."

One final and important observation concerned the **nature of personal disclosures** after the interviews were terminated and the audio recorder was switched off. I noticed that several therapists spoke more openly and candidly about their experiences and/or disclosed more personal information about themselves after the interview. And for some, there were noticeable changes in their body language, with some therapists appearing more relaxed post-interview.

Chapter 5-Discussion

Overview

In this chapter, I provide a brief summary of the findings before discussing the research findings in relation to the theory and existing literature. I then consider research implications and make recommendations for practice. Finally, I critically evaluate the research, outline dissemination activities and impact of research and close the chapter by identifying areas for future research.

Research Findings and the Existing Literature

This study explored therapists' experiences of working with suicidal students in HE. IPA was used to analyse participants' accounts of their experiences, from which four superordinate themes emerged.

A Metaphor: Walking the tightrope

The findings have shown that the metaphor of walking a tightrope, as referenced by Linehan (1999) in the critical literature review in chapter two, perfectly epitomises therapists' experiences of working with suicidal students in HE. Just as walking the tightrope is, in essence, a balancing act, the therapist working in HE, too, faces the challenge of balancing a number of complex (and sometimes conflicting) tensions when working with suicidal students. This study set out to explore those tensions.

The findings revealed that therapists needed to navigate their way around working with the phenomenon of suicide. Just like walking a tightrope, working with suicide as a phenomenon was experienced as anxiety-provoking and burdensome. For most therapists, the stakes of working with suicidal students were high in the sense that if they made one wrong move,

there was a risk of falling to their metaphorical death. There was a reliance on intuition and implicit communication to help them assess suicidality. Additionally, the long-term effects of working with suicide were thought to be life changing and the need for self-care and support was highlighted.

Therapists in HE also needed to be mindful of their own therapist self in working with suicidality, which included exploring their own relationship to suicide and personal attitudes. Just as a tightrope walker may consider tools or equipment to improve their performance, there were some aspects which therapists found to be facilitative in the work. Facilitators included the capacity to share/consult with others and supportive colleagues and/or supervisors. Increased self-care and previous experiences of suicide were also highlighted as facilitators.

In the same way that external conditions such as weather or wind speed are important to a tightrope walker, therapists' experiences, too, seemed largely influenced by organisational needs and context. This included university counselling services, the wider university context and the student population. Therapists reported the need to hold and manage several tensions presented by the university counselling service and these pressures included navigating increasing demands, challenges with the brief model in working with suicidality, lack of risk management and issues related to joint working with external services.

Therapists also spoke about the wider university context which, at times, felt overwhelming and placed extra pressures and responsibilities on them. The university context, with its conflicting agenda to the ethos of university counselling and unrealistic expectations of university counselling, was experienced as uncontaining, and panic-ridden in response to suicide. Noteworthy parallel processes were evident across therapy rooms, counselling services and universities. Anxiety extended from the therapy room to the wider institution, with increasing concerns around scrutiny and accountability amongst both therapists and

universities. In addition, therapists spoke about a “need to do something” in order to reduce anxiety and protect themselves from feeling incompetent. Likewise, universities, in experiencing anxiety about student suicide, also felt compelled to “do something” in order to protect the reputation of the institution.

Finally, as part of the organisational context, suicidal students themselves were important to therapists. Therapists spoke about the multi-faceted nature of student suicidality. They also highlighted how students’ impulsivity and rapidly changing internal environments, and the academic context (i.e., lengthy academic breaks) presented challenges to the therapy work. Despite this, therapists were generally positive about their work with suicidal students.

In conclusion, again, drawing parallels with the metaphor of a tightrope, the findings pointed to the need for a balancing act among therapists working in HE, and a major challenge for these therapists centred around how to manage tensions and (sometimes) conflicting needs between the university, counselling service, students and the therapists themselves.

I will now discuss each theme in turn and in more detail, in reference to the extant literature.

Exploring suicidality

In this study, therapists reported that working with suicidal students evoked anxiety, fear, feelings of impotence and a heightened responsibility, all of which is consistent with the literature on working with suicidal clients (Fox and Cooper, 1998; Moerman, 2011; Panove, 1994; Richards, 2000). As a result of feeling burdened by the work, many therapists identified a need to defend against anxiety evoked by suicide, through doing something about the suicide risk. It is worth noting that a preoccupation with a need to do something about suicide was even reflected in the suicide literature, where vast amounts of literature focused on assessment, prediction or management of suicide risk. I agree with Hendin

(1981) who commented, “in reviewing articles written in the past thirty years on the treatment of suicidal individuals, one is struck with how often the word ‘management’ is used synonymously with therapy” (p. 469). When reflecting on why we feel the need to do something about suicide, I was drawn to Maltsberger’s (1989) assertion that the need to do something is a form of countertransference associated the phenomenon of suicide. As Maltsberger (1989), cited in Sussman (1995), explained, suicidal clients evoke a “strong countertransference wish to do something active, powerful, healing, so that the therapist will not have to endure the empathic pain of experiencing the patient’s despair” (p. 205). This was repeatedly echoed in the interviews where I experienced, on an implicit level, just how intolerable the idea of suicide was for therapists. In particular, I noted a reluctance amongst some therapists to engage with the hopelessness and despair in their suicidal students. Intriguingly, I was surprised to see that comparatively little was said about what it was like “in the room” working therapeutically with a suicidal student, despite my prompts during interviews.

Exploring countertransference further, therapists reported anxiety, fear and frustration as negative countertransference responses to working with suicidal students. Interestingly though, I was curious about the lack of anger from all eight therapists interviewed, despite previous research highlighting anger as a countertransferential response (Fox and Cooper, 1998; Leenaars, 2004; Reeves and Mintz, 2001; Richards, 2000; Trimble et al., 2000). In fact, the only anger expressed during interviews, was towards the institutions themselves, in terms of how they managed suicide risk and team expectations around working with risk. Contemplating on this, I wondered whether there was a degree of displacement of anger in therapists and questioned whether perhaps it felt safer for therapists to direct their anger towards institutions, rather than the students themselves. I also wondered whether anger may have emerged in a second or third interview, after having developed greater trust with the interviewer. Nevertheless, the issue of countertransference is clearly extremely important for the therapy relationship with suicidal students. Acknowledging countertransferential

responses is not only helpful for establishing and maintaining therapeutic contact (Leenaars, 2004), but carrying too much unprocessed anxiety can also affect the therapy relationship and contaminate the work (Yager & Feinstein, 2017). Research suggests that poor management of these countertransferential responses can have harmful consequences, with reports of negative countertransference amongst therapists correlating with negative treatment outcomes (Marcinko et al., 2008). More worryingly, Modestin (1987) warned that a failure to manage negative countertransferential responses could, in some cases, push clients to suicide, particularly clients who experience their therapists' responses as rejections (Paulson & Worth, 2002; Weinberg et al., 2010).

The findings from this study revealed that assessing risk was an anxiety-provoking process for therapists. Some therapists reported a degree of uncertainty surrounding predicting suicide and the efficacy of using risk assessment tools was questioned. This is consistent with evidence that suicide risk assessments continue to be considered commonly inadequate (Coombs et al., 1992) and there has been no meaningful increase in the tools' predictive accuracy for suicide over the past 40 years (Reeves, 2018). It was also interesting to note that even though every therapist used risk assessment tools (partly due to service expectations), they actually paid greater attention to intuition and non-verbal communication as a means to assessing risk. This, again, spoke to the implicit communication of suicide and justified the need for heightened attention and alertness amongst therapists when assessing risk. As Heyno (2008) explained, words alone are not enough to pick up suicide risk, "with clients who are contemplating bypassing words to express what they feel, counsellors have to be even more alert to countertransference feelings to pick up cues that cannot be communicated verbally" (p. 180). This goes some way to explain why suicide as a phenomenon, as destabilising and dissociative as it is, cannot be easily or effectively measured.

The findings from this study confirmed that the effects of working with suicidality are long-

term, significant and life changing. In line with research (Pearlman and Saakvitne, 1995), all of the therapists spoke about profound changes in the core aspect of the therapist's self. i.e. changes in personality, relationships, therapeutic practice and/or views on life and the world, as a result of their work with suicidal students. The majority of therapists reported that their practice had changed over time and observed that their levels of trust and confidence in their capabilities to work with suicide had increased over time. This is consistent with findings from a retrospective study which examined therapy factors in treating suicidal clients (Modestin et al., 1992) and found that the therapists of clients who did not commit suicide had substantially longer professional experience. The implication of this study, although a tentative one, was that with more experience came a greater understanding of suicidality and thus, possibly, an increased ability to maintain a therapeutic relationship with clients, based on mutual respect and trust. This is a potentially ambiguous area, however, as contrasting findings from Neimeyer et al. (2001) indicated that counsellors with lengthy experience of working with suicide did not respond appropriately to potentially suicidal clients.

Therapists, on the whole, were quite positive about their work and therefore, it is possible that these therapists were able to buffer the effects of any VT from working with suicidal clients. This could have been due to their increased levels of confidence and competence, which is supported by with research has found that having a high sense of professional self-efficacy, or confidence in their professional competency, can serve to buffer the impact of VT exposure (Cherniss, 1993). It is also possible that a positive attitude towards the work came from the support they received from peers and supervisors. Again, supported by research, supervision, and peer support (as well as specialised training and debriefing) have been found to buffer the effects of VT (Calderón-Abbo et al., 2008; Trippany et al., 2004). Therapists also tended to focus more on the positive effects i.e. post-traumatic growth, rather than the negative long-terms effects of working with suicidal students. This may have been because therapists were reluctant to admit fallibilities in relation to the work, and/or

worried about how they might be perceived. It may have also been linked to an omnipotence existing amongst therapists, based on the (subjective, less informed) belief that they could save and rescue each suicidal client at all costs (James, 2005). Moreover, with suicide having the capacity to "confront therapists' omnipotence, leading to a sense of narcissistic failure" (Brown, 1987, p. 107) and loss of self-esteem (Farberow, 2005; McAdams and Foster, 2000), perhaps it was unsurprising that therapists may not want to admit any fallibilities.

The context matters

The university context formed an important part of therapists' experiences of working with suicidal students. Where previous literature noted institutional anxiety around suicide (Reeves, 2018), this study reported similar findings. In addition to anxiety, therapists also identified a lack of ownership of suicide in universities, which manifested itself through a desire to stop suicide or expel suicide from the institution. A lack of ownership of suicide by universities was also evidenced by a lack of policies in some universities. With a tendency for HEIs to be reactive rather than proactive, policies appeared to be developed **after** a student suicide. Nevertheless, the importance of having a policy in place to guide therapists in their work with suicidal students was stressed. In considering a way forward, Heyno (2008) advised that universities need to release their omnipotent fantasies that all suicides can be prevented and in that, accept their own responsibility for student suicide, rather than projecting it externally. In other words, it is clear that an institutional ownership of student suicide which embeds a "whole university" approach is needed (UUK, 2017). To some degree, this responsibility or ownership of student suicide extends to the student population itself. Interestingly, changes are occurring in this respect, as evidenced by the University of Wolverhampton (UUK and Papyrus, 2018) who have introduced "First Responder" training and a "Three mins to save a life" initiative, as part of an induction to train students on self-care, suicide/self-harm awareness, resilience and resourcefulness.

Additionally, there was a unanimous agreement amongst therapists about conflicting agendas existing between universities and their counselling services, with universities concerned with retention as opposed to student welfare. Bishop (2016) highlighted similar ethical tensions for counselling services, but found that even with counselling, high risk students were more likely to drop out than low risk students and having more sessions did not necessarily reduce the risk of drop-out. In light of this, Bishop advised that it was unethical for therapists to retain students who were disrupting the college community or emotionally unable to succeed in the college environment.

Therapists also described cultural shifts in the academic environment, moving from a place of learning to a business, in which students were viewed as customers, a view aligned with Jenkins (2016). As a result of this cultural shift, therapists alluded to a process of de-personification occurring in relation to students, with responsibilities falling on therapists to balance the needs of the institution with the students' mental health needs. Most therapists also spoke about a blame culture existing within their respective institutions, consistent with Heyno's (2008) description. Therapists also reported universities' concerns with wanting to protect their reputations, in the event of a completed student suicide. Interestingly, very few therapists referred to a fear of litigation, which is inconsistent with previous studies (Reeves and Mintz, 2001). I was curious about this omission and questioned whether working in a large organisation, in some ways, offered some degree of protection to therapists, as opposed to working in alone in a private practice.

Dealing with institutional demands proved challenging for most therapists, particularly due to misconceptions about the university counselling service and their parameters of working. Often with a poor understanding of counselling, the wider university perceived suicidal students to be the property of university counselling services, which, again, highlighted the lack of ownership of student suicidality within institutions. The majority of therapists regarded their university counselling service as separate from the wider university, which was

inconsistent with Jenkins' (2016) observations. In fact, therapists described a clear disconnect between counselling and university departments, a finding consistent with the RAPPS study (Stanley et al., 2007), who reported poor communication between universities and their support services. Again, more work is being done in this respect to integrate university departments, with the introduction of the Step Change Framework (UUK, 2017), which encourages universities to adopt a whole-university approach.

The student population, as a whole, played an important part in therapists' experiences. According to most therapists, student life brought with it, multiple pressures, which in turn contributed to suicidality in this population. In line with literature (Bell et al., 2010; RCP, 2011; Stanley et al., 2007; Stanley et al., 2009), therapists cited isolation and academic expectations as contributors to suicidal ideation in students. Therapists also considered current student distress in terms of the wider societal context. In particular, they linked distress to the current political instability in recent years, hinting that students nowadays were experiencing quite unique pressures compared to their counterparts in previous years. For me, this raised the question of whether students today face, not just unique pressures, but also increased pressures, compared to their counterparts in previous years. I was also curious about the role of social media in student life, and in particular, the link between social media and suicidality. Interestingly, the role of social media in promoting suicidal behaviour has been explored by Bristol university who found that exposure to suicide content served to validate suicide as acceptable course of action for students (Biddle et al., 2016).

When considering working with the student population therapeutically, the academic context presented challenges due to lengthy and multiple academic breaks which resulted in pauses in treatment, a finding which was consistent with research (Tarren, 2016). These rapidly-changing environments in the academic context (caused by the academic breaks) do also appear to be at odds with the slowing down process which is needed in therapy and

therefore, the task of building a therapeutic alliance is challenged. Academic context aside, the students, themselves, also presented with a unique set of challenges to therapists. Apart from students' unpredictability and impulsivity listed as barriers to engaging fully with the therapy process, therapists reported an unwillingness amongst students to seek support from university counselling services. This is consistent with the RAPSS study (Stanley et al., 2007) which found that a number of suicidal students failed to engage with services early on enough or in enough depth. This begs the question, why are students so difficult to reach? Firstly, being in an academic environment, students may worry about how their mental health will impact their studies, highlighting possible fitness to practice issues (Sayburn, 2015). Therapists in this study also identified that a general reluctance to seek support could be linked to the stigma of suicide, a finding which is supported by previous literature (Calear et al., 2014; Chan et al., 2014; Yakunina et al., 2010). Although not reported in the findings, the RCP (2011) also highlighted students with long term mental health issues who encountered difficulties with accessing treatment at home due to being registered at two addresses, and therefore called for a better continuity of care between home and university health services (RCP, 2011).

In spite of any anxiety or fear reported, it was encouraging to see that there was a sense of hope amongst therapists, in working with suicidal students. In fact, every therapist showed a willingness to address suicidal ideation in the room with a student. These findings conflict with previous research which found that there was a reluctance amongst therapists to explore suicidal ideation (Cole-King and Lepping, 2010a; Feldman et al., 2007; Hendin et al., 2006; Oordt et al., 2009). Although I was surprised by how many therapists were willing to address suicide directly with students, I was also mindful that all of these therapists volunteered and put themselves forward for this study. In light of this, I wondered whether some of them were actually more at ease with the topic, and therefore perhaps more comfortable in talking about suicide with their clients.

What helps?

Returning to the metaphor of walking the tightrope, the reality for all therapists, is that the tightrope will never disappear in HE. In other words, working with suicidal students will always hold a certain degree of risk for therapists. Because of the risks associated with working with this client group, it is clear that a safety net is needed to catch therapists, if or when they metaphorically fall. In many ways, this research has attempted to further understanding of what this safety net could be comprised of and explored what therapists need to steady themselves when walking the tightrope with suicidal students.

Consistent with previous research (Carter, 1971; Litman, 1965), therapists in this study indicated that sharing concerns with others was invaluable when working with suicidal students. In considering the reasons for this, it is possible that sharing concerns, in the spirit of a "problem shared is a problem halved", is a way of decreasing or offloading the anxiety and responsibility that therapists experience in supporting suicidal students. Perhaps the subject of suicide becomes more digestible when sharing the responsibility or ownership of suicide risk as it involves sharing (or even diluting down) the potency of the phenomenon of suicide, and the anxiety which accompanies it. This is supported by research by Trimble et al. (2000) who, when examining a sample of Australian psychologists' responses to completed suicide, reported that decreasing the sense of responsibility was one of the most effective coping strategies. Ellis (2004), too, stressed the need for an understanding of "shared responsibility" between therapist and client. On a final note, active communication between therapists in the same service system is recommended in suicide risk management, following a study by Hendin et al. (2006) who, when examining cases of patients who died by suicide, reported that a lack of communication between therapists was a key factor.

This study also highlighted the need for support from others when working with suicidality. Research certainly supports this, especially in the event of a completed suicide where

therapists rely most commonly on informal sources of support from peers and co-workers to process the event, and formal support from professional supervision (Kleespies and Dettmer, 2000; Seguin et al., 2014). In fact, current quantitative literature shows that social support is a key factor which enables therapists' post-traumatic growth (Brockhouse et al., 2011; Linley and Joseph, 2007; Linley et al., 2005; Mairean, 2016). Another point to consider, which has been mentioned previously, is that suicide is individualising (and splitting) and leads to therapists feeling isolated when dealing with the burdensome nature of the work. In light of this, receiving support from colleagues ensures that therapists are not left holding suicide alone. The same could be said for supervision, which therapists considered important support systems. Supervision, too, is thought to reduce feelings of loneliness amongst therapists and ease the process of unburdening difficult feelings (Gitlin, 1999; Tillman, 2006). Moreover, an overall supportive environment has also been found to improve therapy outcomes in suicidal clients, with Falkenström et al. (2018) identifying low conflict and high co-operation among staff as factors associated with improved therapy outcomes with suicidal clients. For me, this understandably raises concerns for therapists who are sole practitioners in small HEIs, and for whom access to support may be limited. And finally, support for therapists is an important issue, even more so because therapists' support needs can be often overlooked due to the misconception that therapists have "superior, even superhuman capacity for coping" (Valente, 1994, p. 619).

Almost all of the therapists interviewed had some previous experience of suicide, and the findings suggested that such experiences (professional or personal) aided them in their work. Surprisingly, these findings were contrary to research by Neimeyer et al. (2001) who reported that a personal history of suicidality or experience with suicidality was negatively related to suicide intervention competencies. Neimeyer et al. (2001) found that such therapists responded less appropriately to suicidal threats made by clients, than therapists with no personal history or experience of suicidality. In my study, conversely, therapists reported that their personal experiences of suicidality actually increased their empathy and

congruence when sitting with suicidal clients. In an unexpected twist, however, a few therapists seemed genuinely surprised that they had not previously connected how their own personal stories around suicide impacted their clinical work, an observation which made me question whether there was an element of dissociation in some therapists. In many ways, it also made me question those therapists' unconscious motivations in wanting to participate in the study, possibly as a way of resolving their own personal experiences of suicide or overcoming any VT.

Unsurprisingly, every therapist unequivocally highlighted the importance of self-care when supporting suicidal students, which was consistent with recommendations from Reeves (2010) and professional bodies i.e., Code of Ethics and Professional Practice for the UKCP (2019) and Code of Ethics and Conduct for the BPS (2018). There was a general sense that the prospect of working with suicidal students was not even conceivable without good self-care. All of the strategies employed appeared to focus on ways to detach from the phenomenon of suicide, whether this was through changing clinical practice such as creating firm boundaries or through more physical means such as exercise. Again, this spoke to the powerful nature of suicide, so powerful that there was a need to detach from it, in order to survive it. As such, the focus also remained on finding ways to create safety and containment for each individual therapist.

Barriers to working with suicidality in university counselling services

The university counselling service placed further pressure on therapists, resulting in them feeling constrained by the context. Every therapist reported increases in the severity and complexity of presentations in students in universities, as well as increases in the overall demands for counselling within their respective institutions. Statistics published by the IPPR support therapists' reports of increasing demand, with 94% of universities experiencing a

sharp increase in the number of students trying to access support services over the past five years, and 61% of services reporting an increase of over 25% (Thorley, 2017).

Almost all of the therapists interviewed offered primarily brief therapy, which was dictated by service expectations. The length of therapy contracts appeared to be a bone of contention for most therapists, leading to a degree of frustration about not being able to practice in the way that they wished. The general consensus was that therapists struggled to use a brief therapy framework to address student suicidality, despite recent research suggesting that brief psychological interventions are effective in reducing suicide (McCabe et al., 2018), although this is not confirmed in an HE setting. For some therapists, their dissatisfaction about the framework appeared to be linked to a sense of powerlessness they experienced in making decisions about therapy contracts. For others, the brief nature of therapy conflicted with their personal ethos of therapy. Interestingly though, therapists did not refer to any specific psychotherapy model in their work. Although there is strong evidence to support the use of problem-solving behaviour, dialectical behaviour therapy (DBT) and cognitive behavioural therapy (CBT) in the prevention of self-harm in adults (Hawton et al., 2016a, 2016b), the issue of modality used with suicidal clients does warrant further consideration. Research suggests that therapists often struggle to stay within their modality when suicidal ideation is expressed in therapy (Winter et al., 2009) and this conflict can impact their experiences of working with suicidal clients. Rubenstein (2003), for example, found that psychoanalytic therapists struggled to maintain a psychoanalytic stance due to fears of rupturing the relationship by focusing on negative transference and idealisation. Moerman (2012), too, found that person-centred therapists struggled to ask direct questions about suicide or develop a clear risk assessment approach with clients, purely because the focus of their work was related to issues around client autonomy and self-actualising tendency.

University counselling service managers also appear to play a key role in therapists' work with suicidal students. Some therapists noted a lack of consistent professional boundaries

amongst managers, which evoked some ambivalence about holding clinical responsibility. I wondered why managers might lack consistent boundaries and, in some ways, questioned whether a lack of boundaries might be linked to the phenomenon of suicide, in that it can be destabilising and there can be an element of splitting and fragmentation which is evidently uncontaining for therapists and managers alike. Moving forward, it is clear that managers of university counselling services play an important role in therapy outcomes for suicidal clients. In fact, managers who are perceived as supportive, inspirational, and respectful have been associated with improved therapy outcomes with suicidal clients (Falkenström et al., 2018). With most therapists having to balance students' needs with the service needs and make key decisions about client care, often in isolation, these findings suggest that managers need to manage suicide risk more effectively.

Liaison with external services (NHS and voluntary sector) formed a significant part of therapists' work with suicidal students due to limited resources reported within university counselling services. Several therapists engaged in a wider debate about NHS thresholds, and the role of university counselling services in plugging gaps in the NHS. These therapists highlighted the need for improved information-sharing protocol between universities and local health services and identified that a continuity of care and effective communication with NHS was a key part of health care provision for suicidal students. This was consistent with the RAPSS study which concluded that improved communication needed to exist between NHS primary care and university support services in order to prevent suicide (Stanley et al., 2009). This, for me, highlights that integration appears to be at the very heart of effective service provision for suicidal students. In line with this, more recently, the "Minding Our Future" report (UUK, 2018) recommended the integration of university support with NHS care. In accordance with this, some universities, NHS organisations and local authorities have started to form local partnerships to develop mental health strategies to improve services for students (UUK and Papyrus, 2018). The University of Bristol, for example, following a cluster of suicides widely reported in the media, collaborated with Public Health

England and Bristol City Council to develop a suicide prevention policy (UUK and Papyrus, 2018). Finally, with a report by UUK and Papyrus (2018) suggesting that one in three people who die by suicide are known to mental health services, it is imperative that there is greater joined-up thinking between HE and the NHS in the future.

Other important observations

Training. Surprisingly, the issue of training in suicide did not emerge in interviews, with only one therapist mentioning training, and even then after being prompted by the interviewer. Although every therapist expressed anxiety in working with suicidal students, this did not translate into needing further training on suicide. This is very much at odds with existing research in which the majority of psychologists have questioned the adequacy of their training in preparing them to work with suicidal clients (Trimble et al., 2000). When considering the reason for the omission of training amongst therapists in this study, it is possible that they generally felt confident in working with suicidality, however I also wondered whether identifying training needs might expose vulnerabilities in working with such a population. I was also mindful that training may not have been an issue for them due to their experience, especially as all of the therapists recruited for this study had a minimum of five years post-qualification experience. Training is an important issue as it can influence attitudes towards suicide, especially where research has shown that professionals with specialist mental health training hold more positive attitudes towards suicide and self-harm than professionals without this training (Botega et al., 2007; Herron et al., 2001).

My process. My personal process provided some invaluable insights into the phenomenon of suicide and supported the interview findings. Several themes and parallel processes emerged which warrant further discussion. Firstly, although my task was, in essence, to give voice to the unspeakable and implicit phenomenon of suicide, the theme of censorship reappeared throughout various stages of the research process, from selecting appropriate questions for the interview schedule to selecting extracts to evidence themes. I

was constantly aware of censoring myself and noted my hesitation and trepidation when choosing what to disclose or not disclose. The theme of censorship also manifested itself in participants, resulting in the phenomenon of suicide silencing or de-voicing some individuals. It was interesting to note that for some participants, a fleeting meaningful exchange often occurred in the moments after the audio recorder was switched off. This piqued my curiosity about the censoring effect of suicide and led me to question to what degree therapists might be self-censoring in the interviews. i.e. what were they not saying? On this point, it is important to return to the participant who was withdrawn from the study due to non-communication post-interview. Reflecting on what was being communicated to me through the therapist's silence, as is common with suicide, the silence and non-responsiveness left me with many answered questions and fantasies about the interview and its' impact on the therapist. In many ways, I noticed that this process mirrored the work with suicidal students, where some students may disappear, leaving therapists with many unanswered questions.

On the flip side and linked to censorship, the theme of exposure also resonated throughout the research process. When selecting extracts, I was sensitive to exposing therapists' vulnerabilities as I questioned whether extracts were too shaming or exposing for individuals, particularly if therapists shared their own suicidal history with me. Given the sensitivity around the topic, I was mindful of my ethical responsibilities to minimise any harm to my participants throughout the research process, however, at times, I also felt conflicted. For example, I acknowledged that my instinct to protect a therapist who had experienced a client suicide, conflicted with my desire to give voice to the shame that the therapist experienced. To conclude, I realised that a parallel process around exposure and censorship occurred at a variety of levels, in clients, therapists, universities and researchers. Just as I struggled with concerns around exposure and fear of judgment around suicide, this was also mirrored in suicidal clients, therapists and universities.

Research Implications and Recommendations for Practice

Therapists and care of suicidal students

This research has implications for therapists and the care of suicidal students in university counselling services. The findings will prove useful to all therapists, trainees, trainers, supervisors, and other professionals, and can be used to improve practice and outcome with suicidal students. Clinical practice and therapy outcomes with suicidal students in university counselling services can be significantly improved through supporting and strengthening the therapist role in working with suicidal students. Strengthening the therapist role is particularly important, given the recurrent experience of feeling powerless and silenced, as a group. These findings have indicated that therapists need to start feeling more empowered and use their voices more in relation to their work with suicidal students. The findings also highlight the need for increased agency and capacity to make key decisions about their work with suicidal students.

In light of suicide being destabilising for therapists, the findings have identified that certain structures and frameworks which provide safety for therapists need to be in place, in order for them to work safely and ethically with suicidal students. This “safety net” includes containment, reflection, support and training, which I will now explore in greater depth.
The findings show that therapists need a non-shaming space to work in and one which provides object consistency and containment. Universities have a key role in providing that containment for therapists as well as suicidal students. For therapists who fear litigation when working with suicidal students, the containment may take the form of institutional protection and backing, in the event of a suicide. As Barden (2019) asserts, “professionals working in a university’s counselling and mental health services in particular need to know that they will be supported in their work by the institution” (p. 173). Containment could also be provided through managers of counselling services establishing clearer and firmer professional boundaries in regard to managing risk. In fact, research has shown that clear

role definitions are associated with improved therapy outcomes for suicidal clients (Falkenström et al., 2018). Additionally, it is clear from the findings that therapists turn to their institutions for guidance when dealing with suicidality and therefore institutional containment can also be provided through developing clearly structured guidelines, in the form of institutional protocols and policies (in collaboration with third parties including government) on managing suicide risk.

The findings also support the need for more reflection among therapists, particularly with suicide being such a potent and destabilising phenomenon to work with. Moreover, with having to manage heavy caseloads due to increasing demands on counselling services, therapists do not have sufficient time or space to reflect on their work with suicidal students. The findings suggest that insufficient time for reflection can potentially lead to a lack of clarity in thinking and adversely impact therapy work with suicidal students. In light of this, it is recommended that therapists prioritise time to process their work with suicidal students by incorporating regular time for individual reflection during their daily schedule. Having such time for reflection could also allow therapists to explore their own relationship with and attitudes towards suicide.

Given that working with suicide can feel isolating and burdensome for some therapists, support from peers has been unequivocally identified as a major facilitator in working with suicidal students. Fostering good team relations within university counselling services is extremely important when working with suicidality, and therefore it is recommended that university counselling services explore ways to increase support for their team, either in-house or externally, through therapist communities or professional networks specifically targeted at working with student suicidality. Having such a platform would allow therapists to form a group identity, thereby reducing any sense of isolation, develop a greater role clarity in working with suicidal students and set a benchmark for good practice. Moreover, such

therapist communities could effect strategic change by working closely with governmental bodies, with a view to improving service provision for suicidal students.

The findings also support the important role that supervisors play in the care of suicidal students and therefore has implications for clinical supervisors. Given that suicide creates uncertainty in therapists, supervisors play a pivotal role to therapists by helping them strengthen their professional and personal competencies, confirm their treatment plans, and reaffirm their professional practice (Reeves and Mintz, 2001). According to McAdams and Foster (2000), supervisors can also normalise supervisee's experiences and help them manage any feelings of anxiety which could negatively impact future clinical work with suicidal clients. They can also play a critical role in helping therapists explore negative countertransferential issues which could impact therapeutic relationships with students.

These findings have implications for trainers and trainees. Increased educational preparation around death and loss has been found to reduce death-related anxiety amongst therapists (Benoliel, 1987-8), and for this reason, it is recommended that therapists in the HE sector are offered further training in suicidality. Training can increase therapists' awareness of the challenges in working with suicidality, allow therapists to identify and address negative behaviours (e.g. avoidance and denial), and to relinquish any expectations regarding therapeutic omnipotence (Sanders, 1984). By the same token, positive behaviours (e.g. using support networks and acknowledging grief process) could also be used to promote one's own growth (Horn, 1994). Winter et al. (2009), too, highlights the importance of therapists understanding their own biases about suicide, and suggests that suicide risk training needs to incorporate an exploration of therapists' attitudes toward death and suicide. This type of training has implications for clinical practice as research has found that when therapists have a high level of self-awareness about their underlying personal biases and vulnerabilities, their clinical objectivity and effectiveness are enhanced when working with suicidal clients (Somers-Flanagan and Somers-Flanagan, 1995).

Counselling Psychologists in HE

The findings clearly have important implications for all therapists working in HE regardless of their professional training. Due to the generic student/university counsellor roles that CoPs typically occupy, the implications discussed above are also relevant to the clinical work, supervision and/or service management provided by CoPs working with suicidality in HE. Besides, as mentioned briefly in chapter one, the findings point to a distinctive role for CoPs in HE in regard to working with suicidality. This is particularly important, as it is through completing this research, that I have come to the realisation that there is a degree of invisibility of this profession in the HE sector. This is evidenced by the fact that there is no differentiation of training within the university/student counsellor post, CoP posts per se are not recruited in HE and data on the number of CoPs employed in HE is unavailable. Moreover, in reviewing relevant professional bodies, it is interesting to note that, although the BACP has a university and college division which is targeted at therapists working in HE, an equivalent group does not exist within the BPS, the accrediting body for CoPs. In the DCoP for the BPS, a special interest group exists for CoPs working in the NHS, however, there is no equivalent group for CoPs working in HE. It is possible that the lack of representation of the HE sector in the DCoP is a reflection of the current landscape; the majority of CoPs typically work in the NHS, however they are also starting to occupy progressively varied roles in an expanding range of work settings. Nevertheless, the fact remains that the CoP is an invisible profession in the HE sector, and for me, this points to the re-emergence of the all-important theme of de-voicing.

Moving forward, the role of the CoP in HE needs to become more visible and their voices need to be heard. Just as all therapists need to start re-claiming their voices in their work with suicidal students, this equally applies to CoPs working with suicidal students in HE. As a trainee CoP, I feel it is important to give voice to the CoP profession, and even more so in light of the powerlessness which exists in relation to the phenomenon of suicide. Embodying the counselling psychology values concerned with fairness, equality and social justice, I

would like to issue a call to action for the DCoP of the BPS to develop a special interest group for CoPs working in HE. Having the support of the BPS could be influential for CoPs working in the HE sector, and the group could serve as a forum where members can exchange knowledge and good practice, foster peer support and develop expertise and training. Given that the role appears to be invisible in HE, the group, could also serve as a space where CoPs can promote and explore their roles in developing services for suicidal students in HE. There may also be a value in setting up a jiscmail network for CoPs to share information and/or a subdivision in HUCS for CoPs who are service managers and responsible for strategic development.

The invisibility of the CoP in HE is not solely an issue for the BPS to consider, as university counselling services themselves, can play a role in drawing out the distinctive role of CoPs in working with suicidal students. My own experience of working in the generic role of a student/university counsellor, is that therapists tend to morph into one entity, in their shared endeavour of supporting suicidal students. Although this unified approach can be useful in many respects, heads of university counselling services could also focus on drawing out individuals' strengths, especially when working with a variety of different disciplines as part of a multi-disciplinary team (MDT). Rather than this being a divisive strategy, focusing on individuals' strengths may be a way to celebrate the unique values and qualities that CoPs bring to the MDT and the HE sector, and help clarify their roles to other team members.

Completing this research has led me to conclude that, despite the invisibility of the CoP profession in HE, CoPs certainly have unique qualities to contribute to their work with suicidal students and I believe that there is potential for a more defined role for CoPs in the HE, in regard to working with suicidal students, given their varied skill set. I am mindful that, aside from "meeting the psychological needs of people", the DCoP highlights its' commitment to "leading and influencing the design and delivery of innovative policies and services" (BPS, n.d.) and therefore, in recognising CoPs' distinct roles and expertise in

systemic thinking, there is scope for them to play a vital part in training and service development for suicidal students in the HE sector.

Finally, CoPs also have the potential to develop further research in the much-neglected area of working with suicide. Unfortunately, the invisibility of CoPs in HE sector extends to the research domain, and highlights the need for greater engagement by the CoP profession in suicide research. Moreover, as reflective scientist-practitioners, aside from having an ethical responsibility to keep informed of current research, as it relates to theory, practice implementation and outcome, evaluation and analysis are also aligned with the scientific aspects of the scientist-practitioner model, and therefore these aspects could also prove useful to CoPs in strategic development.

University counselling services

Concerns raised by therapists about the overall service they provide to suicidal students (particularly in relation to the brief model framework) are food for thought for university counselling services. In light of increased demands placed on university counselling services, these services need to carefully consider the support package offered to suicidal students, a task which may call for a redesigning of services to better meet the needs of suicidal students. University counselling services may also need to accept their limitations in supporting suicidal students. With some university support services explicitly refusing support to students presenting with severe psychopathology (Pledge et al., 1998) for example, although deemed controversial, this raises an important debate about who university counselling services can realistically support, and those requiring support beyond their expertise or means. In trying to be a “fit-all service”, are universities simply trying to do too much?

The research has implications for joint-working practices between university counselling

services and external services such as the NHS. Due to reduced resources and increasing demands for counselling in universities, university counselling services are increasingly reliant on onward referrals to NHS services to support suicidal students. This research highlights the need for improved communication and co-ordination between these services, in order to avoid students falling “through the net” and ensure a continuity of care. Finally, it is recommended that university counselling services could play a key role in training NHS teams on student populations and the role of university counselling services, as well as challenging the myths around student mental health including the misconception that students are a healthy population. Doing such training could also encourage closer liaison between services, and hence lead to improved communication between services.

Lastly, there are implications for university counselling services and how they promote their work within their respective institutions. Due to counselling services having a high level of confidentiality attached to them (BACP, 2018; Jenkins, 2017), some counselling services are guilty of silencing themselves, and because of this, there is clearly a need for a cultural shift. Just as CoPs are invisible in HE, university counselling services themselves, also need to become more visible and work towards communicating more effectively with other university departments, rather than remaining discrete and separate entities. It is recommended that closer relations can be developed by university counselling services educating the wider university on their roles and clarifying expectations of the counselling service in working with suicidal students through a range of health awareness/ promotion activities and training.

HEIs

Research implications also extend to HEIs and their roles in addressing student suicidality and supporting therapists within their institutions. The findings show that dissociation is an important aspect of the phenomenon of suicide, and this process is reflected in HEIs’ responses to suicide. The reality is that suicide is a collective responsibility and does not just

fall on the shoulders of therapists to bear. In line with this and supporting the concept of a "whole university" approach, this research recommends an institutional ownership of student suicide. A large part of this includes having a shared vision in regard to risk management, and clarity on institutional values and priorities from HEIs (Barden, 2019).

Universities need to create more space for a dialogue around suicide. Fortunately, the HE sector is starting to engage in discussions around suicide by holding conferences for therapists working in HE. This has been evidenced by the BACP: UC holding its' first conference on "Working with suicide in universities and colleges" in June 2018 and Kings College, London running a conference in "Suicidality in HE" in July 2019. Although this is promising, the focus still remains quite understandably on student suicidality. My hope is that, in discussing student suicidality, some attention will also be given to therapists supporting suicidal students.

Universities also need to change the dialogue around suicide. This entails fostering an environment and culture where students and staff are not ashamed to talk about suicide. It also means creating healthier communities overall. In line with this, Heyno (2008) advises that universities need to create more cohesive environments and become less impersonal, and suggests that by doing so, students will feel less disconnected. Many suicides are also preventable via interventions which build community resilience (WHO, 2014). This is particularly important given that closely woven social networks such as universities make for easy transmission of distress (Stanley et al., 2007). In light of suicide clustering (McKenzie et al., 2005) occurring in university communities and primarily being a phenomenon of youth (Gould et al., 1989), it is essential that we attend to the overall health of university communities.

General public

Finally, this research raises awareness of the challenges faced by students and HEIs within the general public. These research findings point to the need to eliminate the stigma attached to mental health issues within the student population. The way that we talk about suicide in the public domain needs to change, and this is particularly relevant to the media industry, where inappropriate media reporting and portrayal of suicides (including irresponsible and sensationalist reporting) can increase suicide risk (Samaritans, 2018). Preventing suicide is, after all, everybody's business.

Critical Evaluation of the Research

Strengths

This study makes original contributions to the field of Counselling Psychology and Psychotherapy, and in particular to the field of student suicide research. Although previous work has been undertaken on therapists' experiences of working with suicidal clients, this is the first research of its kind in the UK to provide an insight into the experiences of those working with suicidal students in a university counselling setting from a phenomenological perspective.

The interpretative component of this research, too, is viewed as a strength and important in relation to the original contribution of this study. Recognising that I cannot completely bracket my personal preconceptions, I have clearly acknowledged my active role in interpreting the findings. I have tried to adopt a reflective and reflexive approach to the research and strived for transparency by identifying my positionality, outlining the procedures and presenting transcript extracts, in order to allow the reader to reflect on my interpretations and consider possible alternatives. Given that the data is a product of the interaction between the researcher and the participants, alternative interpretations of the findings are plausible. As a researcher, however, my interest lies in organisational

responses to suicide, and hence this is where my interpretative engagement with the texts is apparent and I acknowledge that my personal interest may have led the analytic process in a particular direction.

Limitations

This study presented a few limitations. Firstly, it is important to appreciate that suicide is a difficult and complex phenomenon to study and obtaining good response rates in this research area has, historically, been problematic, which may, in part, be due to suicide still being stigmatised and its sensitive nature. Completed suicide continues to be associated with guilt and shame (Gutin & McGann, 2010; Sanders, 1984) and viewed as a "therapeutic failure" (Menninger, 1991, p. 216). With therapists' concerns about how they are viewed by their peers (Litman, 1965), it is possible that therapists in this study shared experiences which aligned with social expectations, rather than what they really wanted to say.

Additionally, although the sample size was within the range recommended for IPA, a greater diversity within the sample, in terms of location, ethnicity and gender, was needed. Those who participated in this study came from a small selection of universities, in terms of types of universities (Russell group, Pre-1992 and Post-1992) and geographic locations. Therapists based in Wales and Northern Ireland, for example, were not represented in the data. Moreover, although unique in their personalities, backgrounds and experiences, the therapists who participated in this study were all White-Caucasian. Gender, too, was not fairly represented within this sample, with only one out of eight therapists being male, an important observation given that gender has been thought to play a role in determining responses to suicide (Grad, 1996; Gulfi et al., 2010).

The self-selecting method of sampling was another an important consideration, in terms of limitations. The findings were based on a small sample of individuals who volunteered to be

interviewed which means that the findings were suggestive rather than conclusive, with respect to the possible transferability of the findings. Even though this method of sampling ensured that experiences which were of significance to the participants were investigated in line with IPA (Smith et al., 2009), it is possible that the recruitment process for this study attracted therapists who were either highly involved in their role in supporting suicidal students or conversely, therapists for whom there was some unresolved trauma or disturbance around suicide.

Finally, I have to acknowledge my own limitations or blind spots as a therapist and novice researcher. Admittedly, I was naive about impact of studying a topic such as suicide and underestimated the potential for re-traumatisation in both myself and my participants. I was mindful that the interviews were a two-way process, and that the depth of exploration of suicide with participants was dictated, to some degree, by my own willingness to explore suicidality. I questioned "how far did I want to go in exploring suicide with my participants, given my own previous experience of the phenomenon of suicide?" Nevertheless, I attempted to overcome such blind spots through increasing my reflexivity through therapy, supervision, peer reflection and journaling.

If I were to replicate the study in the future, I would consider making the following changes:

- I would change my inclusion criteria to include therapists who are not accredited. Reflecting on this, I naively used accreditation as a benchmark for suitability, and in doing so, it excluded many experienced therapists from this study.
- In honouring the reflexive spirit of IPA, I would include an account of my own experience of working with suicidal students including an overview of my personal assumptions. Looking back, I did not include this due to my own lack of confidence and fear of exposure. By overcoming challenges such as silencing myself within this research process, however, I now accept the intrinsic value of integrating my voice fully into this research alongside my interviewees.

Dissemination and Impact of Research

Dissemination activity 1: Survey for Heads of University Counselling Services

Wishing to create a balance between the individual and institutional aspects of the project, I wanted the research findings to have a broader impact on the sector by reaching those with the potential to make strategic changes in the sector. In order to achieve this, I used my interview findings to create a survey for the professional network, Heads of University Counselling Services (HUCS) in the UK. The purpose of this survey was, predominantly, to provide a space where managers of university counselling services could reflect on key themes identified from the interviews, voice their own concerns about service provision and identify areas for improvement within their respective institutions. I selected a survey as a method of data collection as I considered it an efficient way of targeting a large audience and gathering large amounts of data in a timely manner.

Survey dissemination. A brief and simple online survey was constructed using software from the Survey Monkey website (Appendix 14). Details on the HUCS survey design process can be found in Appendix 13. A recruitment email, with the survey attached, was distributed via jiscmail to HUCS members on 1 July 2019 (Appendix 15). The jiscmail gave access to a diverse range of HEIs across a large geographical spread in the UK. HUCS members were informed via the recruitment email that no personal information including demographics would be collected during the data collection process, in order to protect their anonymity, and to encourage survey participation. Following a poor response rate, a second email reminder was sent out approximately one month later which allowed sufficient time for members to respond. The survey was closed down on 31 August 2019.

Survey findings and reflections. Unfortunately, the response rate to the HUCS survey was extremely poor, despite two recruitment drives, with only four members in total completing the survey. I initially wished to use thematic analysis to analyse the survey

findings as it offered flexibility in interpreting data and allowed me to work with large data sets. However, because of a poor response, a thematic analysis was not possible, and so I decided to provide a brief summary of survey responses instead (Appendix 16).

Overall, the findings indicated that HUCs members echoed the sentiments of the therapists' interviews, in terms of the pressures they experienced in working in a university counselling service and working with the wider university and external services. There were, however, noticeable differences in two key areas: HUCs members were more optimistic than therapists in their views about therapists holding clinical responsibility and therapist engagement in decision-making about risk management.

Reflecting on the survey itself, I have considered possible explanations for the poor response rate:

- Poorly designed survey. i.e., too lengthy, vague or leading questions
- The efficacy of surveys generally is called into question, particularly as they can be ineffective and possess inherent limitations. Online surveys, in particular, do not have high response rates (Yan and Fan, 2010) and can be ineffective for investigating vulnerable phenomena, such as suicide, as they cannot capture the essence of individuals' experiences and do not encourage a dialogue or co-creation of meaning-making. Surveys are also not aligned with the spirit of IPA, and instead, closer to a positivist methodology
- The survey was sent out at the end of the academic year, so members may have been away or experiencing high levels of exhaustion
- As managers, they may have been experiencing busy workloads and therefore lack time to complete the survey
- Questionnaire fatigue
- The topic of suicide may have proven too difficult to think about or members may

have struggled to talk about suicide due to its stigma

- Unconscious processes may have been responsible for poor responses. i.e. members may have "forgotten" to complete the survey
- Members' fears that their work was being audited or they were being scrutinized

In many ways though, although disappointing, the poor survey response rate perhaps evidences managers' difficulties in engaging with the topic of suicide, as highlighted in the interviews with therapists, and strengthens the argument for the need for managers to pay greater attention to suicide risk management.

Dissemination activity 2: Presentation of findings to a university counselling service

Due to the survey having a minimal impact on the sector, I considered other ways of disseminating my findings in a meaningful way. I wished to bring the topic of my research alive and decided to do this by sharing my findings directly with those working in university counselling services across the UK. In this vein, I agreed to present my findings to a university counselling service in June 2019, as part of their annual conference, following an invitation by one of my interviewees. Prior to the presentation, I met with the interviewee briefly to explain the purpose of my presentation and to reaffirm the confidentiality of their interview responses. The presentation of my interview findings to a group of therapists provided therapists with an opportunity to engage in an important and invaluable dialogue about working with suicide. The notes from this presentation can be found in Appendix 17.

The feedback from the presentation was very positive. There was a general consensus amongst therapists that the findings resonated with their own experiences of working with suicidal students, with some therapists describing the presentation as "validating". Comparable with the interviewees, therapists spoke about a lack of time to focus on this area of their work and appreciated carving out time to consider and contemplate this aspect

of their work for their annual conference. Some therapists also commented on the usefulness of an exercise, in which I asked therapists to contemplate on the word “suicide” and simply pay attention to their bodies. Some commented that they had “never really sat and thought” about suicide in this way or noticed the impact on their bodies. Finally, therapists highlighted the value of rolling this presentation out to other university counselling teams, confirming that they had found the session helpful as a starting point to reflect on their work with suicidal students.

Reflections on research dissemination

One valuable lesson that I have taken away from the dissemination activities above, is that the dissemination of suicide research needs careful consideration, and the topic of suicide necessitates time and space to be contemplated, discussed and aired. As a researcher, I need to wear my “ethical hat” when considering ways to impart information about my research and am mindful of the need for sensitivity to powerful unconscious processes related to suicide which might occur in the dissemination activity. Reeves (2015) recommends employing a variety of dissemination activities, and in line with this, I have considered other ways of using my research to directly impact the HE sector. Looking to the future, I hope to target my research findings directly at decision-makers of university counselling services and therapists working with suicidal students, and share my research in meaningful ways which encourage dialogue and debate about this sensitive topic. Based on the earlier discussion around DCoP for the BPS, I also wish to explore publishing my research in the DCoP journal for the BPS and register interest in setting up a special interest group for CoPs working in HE in the DCoP.

Areas for Future Research

Although this study successfully achieved the research aim of enhancing understanding of

therapists' experiences of working with suicidal students in HE, I strongly support the need for further research in this area, and with the HE sector paying greater attention to the topic of suicide, it is imperative that researchers follow suit. In terms of future research, it would be interesting to replicate this research and extend the sample to include therapists from more HEIs, with differing demographics and over a larger geographic spread. Comparative research could also be informative. For example, it may be interesting to explore whether therapists' experiences of suicidal students vary across different types of university or locations. In this study, the link between the university type and therapists' experience of working with suicidal students was not consistently discussed across interviews, but I appreciate that this area is worthy of further exploration. Furthermore, therapists in this study mainly referred to their experiences of working with suicidal students who fell within the 18-25 age demographic. Given that increasing numbers of mature students continue to enter HE, this study could be replicated profitably examining therapists' experiences of working with suicidal students which extend to mature students.

I would also suggest that future research needs to focus on the organisational or collective experience of working with suicidality in HE. With a specific interest in strategic development, I am particularly interested in how decision-makers within university counselling services manage suicide risk. In line with this, it would be interesting to explore heads of university counselling services' experiences of managing suicide risk, in order to gain an understanding of how they view their role and their priorities in service provision for suicidal students. When designing this research initially, I was curious about whether having a dual role (i.e. as a manager and therapist) would make a difference to therapists' responses in relation to working with suicidal students. As my analysis was based on those in therapist roles only, unfortunately it was not possible to make comparisons with those in dual roles and explore any differences in responses. Nevertheless, I am curious if managerial-therapists' responses would have differed much from my current data. Moreover, the poor response to the HUCS survey has also made me question the degree to which

managers' voices are represented in relation to suicide risk management in the sector. Given that managers play an important strategic role in shaping university counselling services, exploring their experiences could shed light on ways to improve service provision for suicidal students in the future.

Finally, it may be interesting to explore the interplay between university counselling services and external support services (statutory and voluntary) when supporting suicidal students. Joint working has been highlighted as a key concern for therapists in this study, however this remains an area which is lacking research. In particular, it would be interesting to consider how a co-ordinated response between services could impact the quality of service experienced by suicidal students.

Chapter 6-Summary and Conclusions

Overview

In this chapter, I present a summary of the main findings, a brief reflexive commentary on my overall research journey and close the thesis with some concluding comments.

Summary of the Main Findings

This study set out to explore therapists' experiences of working with suicidal students in HE in the UK. Based on its' philosophical underpinnings and focus on lived experience, IPA was adopted as the most fitting research method to address the research aims, and participants' experiences of working with suicidal students were explored using semi-structured interviews.

All of the therapists interviewed provided rich and insightful accounts of their personal experiences of working with suicide students in HE, which reaffirmed the inherent value of undertaking such research. Given the nuanced, individual and highly complex nature of suicide, it was not possible to arrive at a definitive account of the experience of working with suicidality in HE. Therapists faced a multitude of pressures, and important patterns in individuals' experiences were identified in relation to 1) exploring the phenomenon of suicide 2) the HE context 3) facilitators in the work, and 4) barriers to working with suicidality in university counselling services.

First and foremost, the therapists interviewed described their experiences of working with suicidal students as highly emotional journeys and the process of suicide exploration, itself, was found to be challenging on many levels. Accounts were dominated by experience of powerlessness and impotence, leaving most therapists feeling burdened and anxious. The

long-term impact of working with suicide was also recognised, with most therapists generally noting positive outcomes from doing this work. Therapists also acknowledged the value of suicide exploration and showed a willingness to address suicidality in the room with students.

Although the task of suicide exploration itself was difficult, the university, as a whole, and its' relationship with suicide also played a significant role in therapists experiences, placing additional pressures on them. According to many therapists, universities were reluctant to take ownership of suicide and with conflicting agendas and a need to protect their reputation, they were seen to be projecting their anxieties about suicidal students onto counselling services, leaving them to "fix the problems". Students, as a client population, presented further challenges to therapists, not only due to concerns about the current context of student mental health (i.e. well-documented increases in the severity and complexity of student mental health issues), but also due to suicidal students' perceived impulsivity and unwillingness to engage with counselling services for treatment. The academic context also presented difficulties in ensuring the continuity of the therapy process. Despite such difficulties, however, there was an air of optimism in working with students as therapists lauded them for their capacity for change in therapy.

On a more encouraging note, therapists acknowledged that sharing concerns and receiving support from others aided them in their work. Therapists also appreciated that previous experiences with suicide increased empathy and helped guide them in their work and in acknowledging the powerful impact of suicide, they prioritised the need for good self-care.

Finally, therapists encountered various barriers when working in a university counselling service. They grappled with concerns related to working under pressure, using a brief-model framework, the management of suicide risk and communicating with external services.

By way of a conclusion, the literature review in Chapter Two highlighted that relatively little was known about therapists' experiences of working with suicidal students in HE. As hoped, this research used a qualitative methodology to capture the internal processes of therapists and met its' aims and objectives which were to 1) gain an in-depth understanding of therapists' experiences of working with student suicidality in HE; and 2) provide therapists with a space to voice their experiences.

Further qualitative investigation of the themes and their component features is recommended in order to help university counselling services develop ways to better support therapists working with suicidal students. It is also argued that these findings are of particular value to heads of counselling services in HE in improving service provision for suicidal students in the future. The need for a whole-university approach is also highlighted, as is the need for training for therapists and the wider university in how to manage suicide risk. Lastly, as a trainee CoP, I recognise that this research has important implications for CoPs working in HE. There is a potential for the CoP profession to have higher profile roles in HE. To be more specific, CoPs can play a key role, as reflective scientist-practitioners, in developing further research on working with student suicidality and, as systemic thinkers, they have the potential to significantly improve clinical practice with suicidal students and support for therapists in HE.

My Research Journey

Completing this research has been a profoundly rewarding experience. Whilst I initially set off on this research journey with some degree of naivety, I now sit here in the knowledge that suicide research is a challenging task. Studying the phenomenon of suicide has inevitably forced me to revisit my own trauma around a student suicide and working in such shadow areas has been a lonely place. I have also experienced first-hand the potency of the phenomenon of suicide when I was drowning in the data and feeling the need to detach and

dissociate from it. Moreover, in dealing with vicarious trauma and issues concerning death in the interviews, I have also realised that my role, as a researcher of the phenomenon of suicide, has been to provide some form of containment for the therapists that I interviewed.

It is also important to stress that every stage of this research process has provided me with unique opportunities for learning and growth. It has allowed me to consider in greater depth, my own evolving views on suicide and working with suicidal clients, all of which have led to a greater appreciation and acceptance of the realities of working with suicidal students. One key learning that I have taken from this research process is that, as therapists, it is essential to embrace one's powerlessness in working with suicide and accept the risk of working with suicidality as an occupational hazard. I have realised just how powerful suicide can be in silencing individuals. The theme of voicelessness has been prevalent throughout this study, and evident across many levels, as therapists and universities. As a researcher, and trainee CoP, I too have experienced a certain degree of de-voicing, as I explained in the introduction. My hope is that this research represents a re-claiming of voices around the shame that surrounds suicide. In a sense, I am re-claiming my voice as a therapist, researcher and trainee CoP and taking back my power through doing this research.

Furthermore, having now come to the end of my research journey, one of the key questions this research has left me wrangling with, is how feasible is it to study a phenomenon like suicide? Is the task of harnessing the implicit unspeakable content of suicide simply an impossible one? Given that so much about suicide can be communicated implicitly and on an embodied level, perhaps we cannot rely on words alone. Perhaps future researchers can focus on the implicit realm of suicide, whilst also accepting that it might not be possible to know everything about this complex phenomenon.

Concluding Comments

This research has been driven by my deep-rooted desire to be conversant about hidden and deeply personal domains, and yet the truth is, it is hard to talk about suicide. Suicide remains a whispered word (Grollman, 2011) and the individual voice often goes unheard. The forbidding nature of suicide means that even the most experienced practitioner can struggle with naming suicide with a potentially suicidal client or be reluctant to enter into a client's suicidal phenomenological space (Reeves, 2015). And yet, there is a value in exploring suicide with clients and within ourselves. As Reeves and Mintz (2001) explain, avoiding an exploration with clients about being on "the edge of existence…can only lead to loss, both for an individual and a profession alike" (p. 175). Jones (1987), as cited by Menninger (1991) too, highlights the opportunities for learning from a client suicide, explaining that it provides,

> an opportunity for us, as therapists, to grow in our skill at assessing and intervening in suicidal crisis, to broaden and deepen the connection and support we give and receive, to grow in our appreciation of the precious gift that life is, and to help each other live it more fully. (p. 141)

Working with death-related issues remains at the cornerstone of therapy practice, and therefore as responsible practitioners, it is imperative that we, as therapists, examine our own attitudes and propensity toward suicide and the extent to which this facilitates or impedes our engagement with suicidal clients. Research has shown that the most frequently identified facilitator in working with suicidal clients has been the clinician's own sense of engagement with the client (Alonzo et al., 2017), and for this reason, it is important that we explore any barriers within ourselves and within the wider contexts and institutions to which we belong, which may prevent us from being fully engaged with our suicidal clients. Given that the clients attending therapy are those that we have the greatest opportunity to help, we have a duty to ourselves and our students, to address and work through any anxieties we have about death and suicide. Openly acknowledging personal anxieties and fears in

working with suicidal students can only serve to increase the potential for positive growth and development amongst therapists in HE. My hope is that further research in this area can empower therapists to share their experiences, so that we can all learn from those lived experiences and find ways to destigmatise suicide, which has become an increasing reality for many students.

Furthermore, responsibilities for caring for suicidal students do not only lie with therapists, but also the HEIs themselves. To illustrate this point, I would like to share the following extract taken from one of the interviews in which a therapist reflected on what the university represented to a suicidal student,

> The university was very much a kind of a stability and a place where he was held, where he felt his connection with family and various other things had been quite chaotic, but it was something about having that base and the university was his base, and at the end, the work was about being able to leave and make a leap into the new, and I just wondered whether there was something about that, that maybe even if someone is suicidal, the university, the higher education institution could be a place of where they can have a base and somewhere safe, and the counselling could be the place where they can explore these feelings…containment and a place of safety, and a kind of something that they may not have had from previous experiences.

This extract epitomises the importance of a university setting for students. The educational environment is more than just bricks and mortar or a place to learn. For many students, it becomes their metaphorical home and for that very reason, the environment needs to offer safety and containment, both within the university counselling service and the wider institution.

Safety and containment are not only needed for students, but also for the staff who work in HEIs. With a reduction in resources for mental health professionals working in HEIs, against

the backdrop of a steady proliferation in student distress in British universities, it is essential that more is done to help this (often) invisible profession. The only way to break the silence around suicide in HE is to continue to push it up the university “agenda”, and to actively start creating a space for a discourse around suicide in universities across the UK.

This research has revealed the powerful impact of working with suicide on therapists working in HE. There is no “we-ness” when it comes to suicide. Suicide is splitting and it becomes very personalised. With so much destabilisation and fragmentation arising from suicide, the coming together and sharing of responsibility for suicide is key, and therefore, a fundamental question for me at this point is, “How do we create a space to share difficult conversations around suicide?” Lastly, whilst I appreciate that there are some places that we don’t allow our minds to go to, my hope is that this research will encourage the reader to reflect on their own experiences of working with suicidal students and perhaps even acknowledge their own suicidal parts. On a final note, I would like to invite the reader to close their eyes, sit quietly, and contemplate on the word suicide and observe what happens…In moving into the implicit realm, my hope is that we can finally start to shape a narrative around the phenomenon that is suicide.

References

Alderson, P. (2004) Ethics. In: Fraser, S., Lewis, V., Ding, S., Kellett, M. & Robinson, C. (Eds.) *Doing Research with Children and Young People.* London: Sage.

Aldridge, D. (1998). *Suicide: The tragedy of hopelessness*. London: Jessica Kingsley.

Alexander, V. (1991). Grief after suicide: Giving voice to the loss. *Journal of Geriatric Psychiatry*, 24, 277-291.

Alonzo, D., Moravec, C., & Kaufman, B. (2017). Individuals at Risk for Suicide: Mental Health Clinicians' Perspectives on Barriers to and Facilitators of Treatment Engagement. *Crisis*, 38, 158-167.

Andrews, B., & Wilding, J.M. (2004). The relation of depression and anxiety to life-stress and achievements in students. *British Journal of Psychology,* 95(4), 509-521.

Araminta, T. (2000). Dialectical behavior therapy: A qualitative study of therapist and client experience. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 61(1-B), 520.

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious post-traumatic growth in psychotherapy. *Journal of Humanistic Psychology*, 45, 239-263.

Barden, N. (2019). Risk and Crisis: Managing the challenges. In Barden, N., and Caleb, R. (eds.) *Student mental health and wellbeing in higher education: A practical guide.* London: Sage.

Bartoskova, L. (2017). How do trauma therapists experience the effects of their trauma work, and are there common factors leading to post-traumatic growth? *Counselling Psychology Review*, 32(2), 30-45.

Beeley, A.L. (1932). Was there a suicide wave among college students in 1927? *Scientific Monthly,* 35, 66-67.

Bell, D. (2001). Who is killing what or whom? Some notes on the internal phenomenology of suicide. *Psychoanalytic Psychotherapy*, 15, 21- 37.

Bell, J., Stanley, N., Mallon, S., & Manthorpe, J. (2010). The role of perfectionism in student

suicide: Three case studies from the UK. *Journal of Death and Dying*, 61(3), 251-267.

Benoliel, J. Q. (1987-1988). Health care providers and dying patients: Critical issues in terminal care. *Omega: Journal of Death and Dying*, 18(4), 341-363.

Bewick, B., Koutsopoulou, G., Miles., J., Slaa., E., & Barkham., M. (2010). Changes in undergraduate students' psychological well-being as they progress through university. *Studies in Higher Education*, 35(6), 633-645.

Bhaskar, R. (1978). *A realist theory of science*. Brighton, UK: Harvester Press.

Biddle, L., Derges, J., Gunnell, D., Stace, S., & Morrissey, J. (2016). *Priorities for suicide prevention: balancing the risks and opportunities of internet use*. University of Bristol. Retrieved from https://www.bristol.ac.uk/media-library/sites/policybristol/briefings-and-reports-pdfs/pre-2017-briefings—reports pdfs/PolicyBristol_Report_7_2016_ suicide_and_internet.pdf.

Birtchnell, J. (1983). Psychotherapeutic considerations in the management of the suicidal patient. *American Journal of Psychotherapy*, 37(1), 24- 35.

Bishop, K. (2016). The relationship between retention and college counseling for high-risk students. *Journal of College Counseling*, 19(3), 205-217.

Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *BMJ*, 351, h4978.

Bongar, B. (1992). The ethical issue of competence in working with the suicidal patient. *Ethics and Behavior*, 2(2), 75-89.

Bongar, B. (2002). *The suicidal patient: Clinical and legal standards of care* (2nd ed.). Washington, DC: American Psychological Association.

Botega, N.J., Silva, S.V., Reginato, D.G., Rapeli, C.B., Cais, C.F.S., Mauro, M.L.F., Stefanello, S., & Cecconi, J.P. (2007). Maintained Attitudinal Changes in Nursing Personnel After a Brief Training on Suicide Prevention. *Suicide and Life-Threatening Behavior*, 37(2), 145-153.

British Association for Counselling and Psychotherapy (2017). *University and colleges counselling services*. Sector Resource 003. Retrieved from https://www.bacp.co.uk/media/2237/bacp-university-college-counselling-services-sector-resource-003.pdf.

British Association for Counselling and Psychotherapy (2018). *Ethical Framework for the Counselling Professions.* Leicestershire: BACP. Retrieved from https://www.bacp.co.uk/media/3103/bacp-ethical-framework-for-the-counselling-professions-2018.pdf.

British Association for Counselling and Psychotherapy (2019). *Ethical Guidelines for Research in the Counselling Professions*. BACP: Lutterworth, Leicestershire. Retrieved from https://www.bacp.co.uk/media/3908/bacp-ethical-guidelines-for-research-in-counselling-professions-feb19.pdf.

British Psychological Society (n.d.) *Careers: Counselling Psychology*. Retrieved from https://careers.bps.org.uk/area/counselling.

British Psychological Society (n.d.) *Division of Counselling Psychology: Our Values and Vision.* Retrieved from https://www.bps.org.uk/member-microsites/division-counselling-psychology.

British Psychological Society (2014). *Code of Human Research Ethics.* Leicester: BPS. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20%20Files/BPS%20Code%20of%20Human%20Research%20E thics.pdf.

British Psychological Society (2018). *Code of Ethics and Conduct.* Leicester: BPS. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf.

Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress*, 24(6), 735-742.

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, 21(1), 87-108.

Broglia, E., Millings, A., & Barkham, M. (2017). Challenges to addressing student mental health in embedded counselling services: as survey of UK higher and further education institutions. *British Journal Guidance and Counselling*, 46(4), 441-455.

Brown, H. N. (1987). The impact of suicide on therapists in training. *Comprehensive Psychiatry*, 28(2), 101-112.

Burns, J. (2017, September 4). 'Sharp rise' in student mental illness tests universities*. BBC News Education.* Retrieved from www.bbc.co.uk/news/education-41148704.

Burr, V. (2003). *Social Constructionism* (2nd ed.). London: Routledge.

Buzan, R.D., & Weissberg, M.P. (1992). Suicide: Risk factors and prevention in medical practice. *Annual Review of Medicine*, 43, 37-46.

Calderón-Abbo, J., Kronenberg, M., Many, M., & Ososfsky, H. (2008). Fostering healthcare providers' post-traumatic growth in disaster areas: Proposed additional core competencies in trauma-impact management. *American Journal of the Medical Sciences*, 336(2), 208-214.

Calear, A. L., Batterham, P. J., & Christensen, H. (2014). Predictors of help-seeking for suicidal ideation in the community: Risks and opportunities for public suicide prevention campaigns. *Psychiatry Research*, 219(3), 525-530.

Campbell, D. (2008). The father transference during a pre-suicide state. In Briggs, S., Lemma, A. and Crouch, W. (eds). *Relating to self-harm and suicide; psychoanalytic perspectives on practice, theory and prevention*. London: Routledge.

Carter, C. A. (1971). Some conditions predictive of suicide at termination of psychotherapy. *Psychotherapy: Theory, Research & Practice*, 8(2), 156-157.

Carver, L. (2017). Student Counselling: what is its future? *Therapy today*, November edition. Leicestershire: BACP.

Chan, W. I., Batterham, P., Christensen, H., & Galletly, C. (2014). Suicide literacy, suicide stigma and help-seeking intentions in Australian medical students. *Australasian Psychiatry*, 22(2), 132-139.

Chan, M. K. Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., Kapur, N., & Kendall, T. (2016). Predicting suicide following self-harm: Systematic review of risk factors and risk scales. *British Journal of Psychiatry*, 209(4), 277-283.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage.

Chemtob, C. M., Hamada, R. S., Bauer, G. B., Torigoe, R.Y., & Kinney, B. (1988b). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice*, 19(4), 416-420.

Cherniss, C. (1993). Role of professional self-efficacy in the etiology and amelioration of burnout. In Shaufeli, B., Maslach, C., & Marek, T. (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 135-149). Philadelphia: Taylor & Francis.

Cholbi, M. (2011). *Suicide: The philosophical dimensions*. Ontario: Broadview Press.

Clothier, C., MacDonald, C.A., & Shaw, D.A. (1994). *The Allitt inquiry: Independent Inquiry relating to deaths and injuries on the children ward at Grantham and Kesteven General Hospital during the period February to April 1991*. HMSO: London.

Colbert, N. (2002). *A qualitative investigation into the experiences of clients and therapist engaged in psychodynamic interpersonal therapy following an episode of self-harm.* D. Clin.Psychol Dissertation, University of Lancaster.

Cole-King, A. & Gilbert, P. (2011a). Compassionate care: the theory and the reality. *Journal of Holistic Healthcare*, 8(3), 29-36.

Cole-King, A., & Lepping, P. (2010a). Suicide mitigation: time for a more realistic approach. *British Journal of General Practice*, 60, 3-4.

Collins, I. P., & Paykel, E. S. (2000). Suicide amongst Cambridge University students 1970–1996. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, 35(3), 128-132.

Connell, J., Barkham, M., & Mellor-Clark, J. (2007). CORE-OM mental health norms of

students attending university counselling benchmarked against an age-matched primary care sample. *British Journal of Guidance and Counselling*, 35(1), 41-57.

Connell, A., Barkham, M., & Mellor-Clark, J. (2008). The effectiveness of UK student counselling services: an analysis using the CORE System. *British Journal of Guidance and Counselling*, 36(1), 1-18.

Conrad, P. (1987). The experience of illness: recent and new directions. *Research in the Sociology of Health Care*, 6, 1-31.

Cooke, R., Bewick, B. M., Bradley, M., & Audin, K. (2006). Measuring, monitoring and managing the psychological well-being of first year university students. *British Journal of Guidance and Counselling*, 34(4), 505-517.

Coombs, D. W., Miller, H. L., Alarcon, R., Herlihy, C., Lee, J. M., & Morrison, D. P. (1992). Pre-suicide attempt communications between parasuicides and consulted caregivers. *Suicide and Life-Threatening Behavior*, 22(3), 289-302.

Coren, A. (1997). *A Psychodynamic approach to Education*. London: Sheldon Press.

Coughlan, S. (2016, May 25). Student suicide figures increase. *BBC News*. Retrieved from http://www.bbc.co.uk/news/education-36378573.

Coughlan, S. (2018, April 13). Student suicide increase warning. *BBC News.* Retrieved from https://www.bbc.co.uk/news/education-43739863.

Coxon, K. (2002, September 10). Fight for survival. *Education Guardian*. Retrieved from http://education.guardian.co.uk/students/story/0,,788920,00.html.

Da Cruz, D., Pearson, A., Saini, P., Miles, C., While, D., Swinson, N., Williams, A., Shaw, J., Appleby, L., & Kapur, N. (2011). Emergency department contact prior to suicide in mental health patients. *Journal of Emergency Medicine*, 28, 467-471.

Data Protection Act (2018). Retrieved from http://www.legislation.gov.uk/ukpga/2018/12/contents.

Department of Health (1999a). *Saving Lives: Our Healthier Nation Cm4386.* London: HMSO. Retrieved from https://www.gov.uk/government/publications/saving-lives-our-

healthier-nation.

Department of Health (1999b). *National Service Framework for Mental Health. Modern Standards and Service Models.* London: DH. Retrieved from https://www.gov.uk/government/publications/quality-standards-for-mental-health-services.

Department of Health (2002). *National Suicide Prevention Strategy for England*. London: DH. Retrieved from http://library.college.police.uk/docs/dh/suicide-prevention-strategy-DH-4062935-2002.pdf.

Department of Health (2015). *Nick Clegg calls for new ambition for zero suicide across the NHS*. London: DH. Retrieved from https://www.gov.uk/government/news/nick-clegg-calls-for-zero-suicides-across-the-nhs.

Deutsch, C.J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice*, 15, 833-845.

Durkheim, E. (1897). *On Suicide: A Study of Sociology*. London: Penguin Books.

Durkheim, E. (1952). *Suicide: A study in Sociology*. Translated by Spaulding, J. A., & Simpson, G. London: Routledge and Kegan Paul.

Elliott, R., Fischer, C.T., & Rennie, D. L. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology,* 38, 215-229.

Ellis, T. E. (2004). Collaboration and self-help orientation in therapy with suicidal clients. *Journal of Contemporary Psychotherapy*, 34, 41-57.

Equality Act (2010) (c.2). Retrieved from http://www.legislation.gov.uk/ukpga/2010/15/part/6/chapter/2.

Falkenström, F., Grant, J., & Holmqvist, R. (2018). Review of organizational effects on the outcome of mental health treatments. *Psychotherapy Research*, 28, 76-90.

Farber, B.A. (1983). Psychotherapists' perceptions of stressful patient behaviour. *Professional Psychology: Research and Practice*, 14(5), 697-705.

Farberow, N. L. (2005) The mental health professional as a suicide survivor. *Clinical Neuropsychiatry: Journal of Treatment Evaluation,* 2(1), 13-20.

Feldman, M. D., Franks, P., Duberstein, P. R., Vannoy, S., Epstein, R., & Kravitz, R. L. (2007). Let's not talk about it: suicide inquiry in primary care. *Annals of family medicine*, 5 (5), 412-418.

Firestone, R. W. (1997). *Suicide and the inner voice: Risk assessment, treatment, and case management.* London: Sage.

Fitch, C., Hamilton, S., Bassett, P., & Davey, R. (2011). The relationship between personal debt and mental health: a systematic review. *Mental Health Review Journal* 16(4), 153-166.

Foster, D. (1995). *A report on the level of student stress and suicide rates*. London: House of Commons.

Fox, C. (2011). Working with clients who engage in self-harming behaviour: experiences of a group of counsellors. *British Journal of Guidance & Counselling*, 39(1), 41-51.

Fox, R. & Cooper, M. (1998). The effects of suicide on the private practitioner: A professional and personal perspective. *Clinical Social Work Journal*, 26, 143-157.

Fremouw, W. J., de Perczel, M., & Ellis, T. E. (1990). *Suicide risk: Assessment and response guidelines.* New York: Pergamon.

Freud, S. (1917). Mourning and Melancholia. In Strachey, J. (ed. and trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. 10. London: Hogarth Press.

Freud, S. (1923). The ego and the id. In Strachey, J. (ed. and trans.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. 19. London: Hogarth Press.

Gagnon, J., & and Hasking, P.A. (2012). Australian psychologists' attitudes towards suicide and self-harm. *Australian Journal of Psychology*, 64, 75-82.

Garfield, S. L., & Bergin, A. E. (Eds.). (1978). *Handbook of psychotherapy and behavior change* (2nd Ed.). New York: Wiley.

Giorgi A. (1992). Description versus interpretation: competing alternative strategies for qualitative research. *Journal of Phenomenological Psychology*, 23(2), 119-135.

Gitlin, M.J. (1999). A psychiatrist's reaction to a patient's suicide. *American Journal of Psychiatry*, 156(10), 1630-1634.

Gitlin, M.J. (2007). Aftermath of a tragedy: Reaction of psychiatrists to patient suicides. *Psychiatric Annals*, 37(10), 684-687.

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4), 597-606.

Goldstein, L. S. & Buongiorno, P.A. (1984). Psychotherapists as suicide survivors. *American Journal of Psychotherapy*, 38, 392-398.

Gould, M.S., Wallenstein, S.W., & Davidson, L. (1989). Suicide Clusters: A critical review. *Suicide and Life-threatening behaviour*, 19(1), 17-29.

Grad, O.T. (1996). Suicide: How to survive as a survivor? *Crisis*, 17, 136-142.

Grant, A. (2002). 'Identifying students' concerns: Taking a whole institutional approach'. In Stanley, N. & Manthorpe, J. (eds). *Students' mental health needs: problems and responses*. London: Jessica Kingsley.

Grollman, E. A. (2011). *Talking about death: A dialogue between parent and child*. (4th ed.). Boston: Beacon Press.

Gulfi, A., Castelli Dransart, D.A., Heeb, J., & Gutjahr, E. (2010). The impact of patient suicide on the professional reactions and practices of mental health caregivers and social workers. *Crisis: Journal of Crisis Intervention and Suicide*, 31(4), 202-210.

Gupta, U. C. (2013). Informed consent in clinical research: Revisiting few concepts and areas. *Perspectives in Clinical Research*, 4(1), 26-32.

Gurrister, L., & Kane, R. A. (1978) How therapists perceive and treat suicidal patients. *Community Mental Health Journal*, 14(1), 3-13.

Gutin, N.J., & McGann, V. (2010). Clinicians and suicide loss. *Surviving Suicide Newsletter* U.S: American Association of Suicidology.

Hammond, L. K., & Deluty, R. H. (1992). Attitudes of clinical psychologists, psychiatrists, and oncologists toward suicide. *Social Behavior and Personality*, 20, 289-294.

Hastings, L. (2015, August 26). *10 reasons why your first year at university will be the best*

of your life. The Independent. Retrieved from http://www.independent.co.uk/student/student-life/10-reasons-why-your-first-year-at-university-will-be-the-best-of-your-life-10472512.html.

Hawgood, J. (2015). Working with suicidal clients: Impacts on psychologists and the need for self-care. *InPsych*, 37, 1. Retrieved from www.psychology.org.au/inpsych/2015/february/hawgood.

Hawton, K., Bergen, H., Mahadevan, S., Casey, D., & Simkin, S. (2012). Suicide and deliberate self-harm in Oxford University students over a 30 year-period. *Social Psychiatry and Psychiatric Epidemiology,* 47(1), 43-51.

Hawton, K., Simkin, S., Fagg, J., & Hawkins, M. (1995). Suicide in Oxford University students, 1976- 1990. *British Journal of Psychiatry*, 166, 444-450.

Hawton, K., & Van Heeringen, K. (2009). Suicide. *Lancet,* 373, 1372-1381.

Hawton, K., Witt, K., Taylor, G., Salisbury, T. L., Arensman, E., Gunnell, D., Hazell, P., Townsend, E., & van Heeringen, K. (2016a). Psychosocial interventions following self-harm in adults: A systematic review and meta-analysis. *Lancet Psychiatry*, 3, 740–750.

Hawton, K., Witt, K., Taylor, G., Salisbury, T. L., Arensman, E., Gunnell, D., Hazell, P., Townsend, E., & van Heeringen, K. (2016b). Psychosocial interventions for self-harm in adults. *Cochrane Database of Systematic Reviews*, 5, Art. CD012189. Retrieved from: https://core.ac.uk/download/pdf/84043202.pdf

Healthy Universities (2010). *Healthy Universities: Concept, Model and Framework for Applying the Healthy Settings Approach within Higher Education in England.* Retrieved from https://healthyuniversities.ac.uk/wp-content/uploads/2016/10/HU-Final_Report-FINAL_v21.pdf.

Heather, N., Partington, S., Longstaff, F., Allsop, S., Jankowski, M., & St Clair Gibson, A. (2011). Alcohol use disorders and hazardous drinking among undergraduates at English universities. *Alcohol and Alcoholism*, 46(3), 270-277.

Hefferon, K., & Gil- Rodriguez, E. (2011). Reflecting on the rise in popularity of interpretive phenomenological analysis. *The Psychologist*, 24(10), 756-759.

Heidegger, M. (1927/ 1962). *Being and time* (Macquarrie, J. & Robinson, E., Trans.) Oxford, UK: Blackwell. (Original work published 1927).

Hendin, H. (1981). Psychotherapy and suicide. *American Journal of Psychotherapy*, 35(4), 469-480.

Hendin, H., Haas, A. P., Maltsberger, J. T., Koestner, B., & Szanto, K. (2006). Problems in psychotherapy with suicidal patients. *American Journal of Psychiatry*, 163(1), 67-72.

Hendin, H., Lipschitz, A., Maltsberger, J.T., Pollinger Haas, A., & Wynecoop, S. (2001). Therapists' Reactions to Patients' Suicides. *American Journal of Psychiatry*, 157(12), 2022–2027.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83(1), 97-111.

Hernandez, P, Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A qualitative investigation into a description of a new concept. *Family Process*, 46, 229-241.

Herron, J., Ticehurst, H., Appleby, L., Perry, A., & Cordingley, L. (2001). Attitudes toward suicide prevention in front-line health staff. *Suicide & Life-Threatening Behavior*, 31(3), 342-347.

Heyno, A. (2004). *The Counselling service as a container*. Paper presentation at the Counselling in Educational Settings Course. London: British Association of Psychotherapists.

Heyno, A. (2008). On being affected without being infected: Managing suicidal thoughts in a student counselling service. In Briggs, S., Lemma, A., & Crouch, W. (Eds.), *Relating to self-harm and suicide*. London: Routledge.

HM Government (2012). *Preventing suicide in England: A cross-government outcomes strategy to save lives*. London: DH. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

HM Government (2019a). *Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772184/national-suicide-prevention-strategy-4th-progress-report.pdf.

HM Government (2019b). *Cross-Government Suicide Prevention Workplan*. London: HMSO. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf.

Horn, P. J. (1994) Therapists' psychological adaptation to client suicide. *Psychotherapy: Theory, Research, Practice and Training*, 31(1), 190-195.

Hubble, S., & Bolton, P. (2019). *Support for students with mental health issues in higher education in England.* House of Commons Library Briefing Paper no. 8593 (21 Aug 2019). London: House of Commons Library. Retrieved from https://commonslibrary.parliament.uk/research-briefings/cbp-8593/.

Hughes, G. & Spanner, L. (2019). *The University Mental Health Charter.* Leeds: Student Minds. Retrieved from https://www.studentminds.org.uk/uploads/3/7/8/4/3784584/191208_umhc_artwork.pdf.

Hunt, J., & Eisenberg, D. (2010). Mental health problems and help-seeking behavior among college students. *Journal of Adolescent Health*, 46, 3- 10.

Husserl, E. (1900/ 1970). *The Crisis of European Sciences and Transcendental Phenomenology*. (D. Carr, Trans.). Evanston: Northwestern University Press.

Jaeger, M. E., & Rosnow, R. L. (1988). Contextualism and its implications for psychological inquiry. *British Journal of Psychology*, 79(1), 63-75.

James, D. M. (2005). Surpassing the quota. *Women and Therapy*, 28, 9-24.

Janoff-Bulman, R. (1992). *Shattered assumptions: towards a new psychology of trauma.* New York: The Free Press.

Jenkins, P. (2016) Counselling in higher education settings: working with risk, confidentiality and duty of care issues. In Mair, D. (ed). *Short-term Counselling in Higher Education*.

Oxon: Routledge.

Jenkins, P. (2017). Therapy and the law. In Feltham, C., Hanley, T., & Winter, L.A. (eds). *The Sage Handbook of Counselling and Psychotherapy*. London: Sage.

Jessop, D.C., Herberts, C., & Solomon, L. (2005). The impact of financial circumstances on student health. *British Journal of Health Psychology*, 10(3), 421-439.

Jobes, D. A., Jacoby, A. M., Cimbolic, P., & Hustead, L. A. T. (1997). Assessment and treatment of suicidal clients in a university counseling center. *Journal of Counseling Psychology*, 44, 368-377.

Johnson, J., Gooding, P., & Tarrier, N. (2008). Suicide risk in schizophrenia: explanatory models and clinical implications. *Psychology & Psychotherapy: Theory, Research & Practice*, 81, 55-77.

Joiner, T. E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.

Jones Nielsen, J.D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom, *Counselling Psychology Quarterly*, 29(2), 206-215.

Kessler, R.C., Angermeyer, M., Anthony, J.C., De Graaf, R., Demyttenaere, K., Gasquet, I., De Girolamo, G., Guzman, S., Gureje, O., Haro, J.M., Kawakami, N., Karam, A., Levinson, D., Mora, M.E.M., Oakley Browne, M.A., Posada-Villa, J., Stein, D.J., Tsang, C.H.A., Aguilar- Gaxiola, S., Alonso, J., & others (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organisation's World Mental Health Survey Initiative. *World Psychiatry*, 6, 168-176.

Keval, N. (2003). Triangulation or strangulation: managing the suicidal patient, *Psychoanalytic Psychotherapy*, 5-51.

Kleespies, P. M., & Dettmer, E. L. (2000). The stress of patient emergencies for the clinician: Incidence, impact, and means of coping. *Journal of Clinical Psychology*, 56, 1353-1369.

Kleespies, P., Penk, W., & Forsyth, J. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*, 24, 293-303.

Kleespies, P. M., & Ponce, A. N. (2009). The stress and emotion- al impact of clinical work with the patient at risk. In Kleespies, P.M. (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization* (pp. 431-448). Washington, DC: American Psychological Association.

Kleespies, P. M., Van Orden, K. A., Bongar, B., Bridgeman, D., Bufka, L. F., Galper, D.I., Hillbrand, M., & Yufit, R. I. (2011). Psychologist suicide: Incidence, impact, and suggestions for prevention, intervention, and postvention. *Professional Psychology Research & Practice*, 42(3), 244-251.

Klein, M. (1952). Notes on some schizoid mechanisms. In Klein, M., Heimann, P., Isaacs, S., & Riviere, J. *Developments in Psychoanalysis*. London: Hogarth

Klibert, J., Langhinrichsen-Rohling, J., Luna, A., & Robichaux, M. (2011). Suicide proneness in college students: Relationships with gender, procrastination, and achievement motivation. *Death Studies*, 35, 625-645.

Klonsky, E. D., & May, A. M. (2014). Differentiating suicide attempters from suicide ideators: A critical frontier for suicidology research. *Suicide and life-threatening behavior*, 44, 1-5.

Langdridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Harlow, UK: Pearson Education.

Large, M., Kaneson, M., Myles, N., Myles, H., Gunartane, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLoS ONE,* 11(6), 1-17.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative p henomenological analysis. *Qualitative Research in Psychology*, 3(2),102-120.

Laufer, M. (ed.) (1995). *The Suicidal Adolescent*. London: Karnac Books.

Leenaars, A. (2004). *Psychotherapy with suicidal people: A person-centred approach*. Chichester: Wiley.

Linehan, M. M. (1999). Standard protocol for assessing and treating suicidal behaviors for

patients in treatment. In Jacobs, D.G. (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (pp. 146-187). San Francisco, CA: Jossey-Bass Publishers.

Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, 26(3), 385-403.

Linley, P.A., Joseph, S., & Loumidis, K. (2005). Trauma work, sense of coherence, and positive and negative changes in therapists. *Psychotherapy and Psychosomatics*, 74, 185-188.

Litman, R. E. (1965). When patients commit suicide. *American Journal of Psychotherapy*, 19, 570-576.

McAdams, C. R.,III, & Foster, V.A. (2000). Client suicide: its frequency and impact on counselors. *Journal of Mental Health Counseling*, 22(2), 107-121.

McCabe, R., Garside, R., Backhouse, A., & Xanthopoulou, P. (2018). Effectiveness of brief psychological interventions for suicidal presentations: a systematic review. *BMC Psychiatry*, 18(1), 120.

McCann, L. & Pearlman, L.A. (1990). Vicarious Traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149.

McKenzie, N., Landau, S., Kapur, N., Meehan, J., Robinson, J., Bickley, H., Parsons, R. & Appleby, L. (2005). Clustering of suicides among people with mental illness. *British Journal of Psychiatry*, 187, 476-480.

Mackley, A. (2019). *Suicide Prevention: Policy and Strategy.* House of Commons Library Briefing Paper no. 08221 (10 Oct 2019). London: House of Commons Library. Retrieved from https://commonslibrary.parliament.uk/research-briefings/cbp-8221/.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructivist epistemologies. *British Journal of Psychology*, 91, 1-20.

Mairean, C. (2016). The relationship between secondary traumatic stress and personal

posttraumatic growth: personality factors as moderators. *Journal of Adult development,* 23, 120-128.

Malin, A., & Grotstein, J. S. (1966). Projective identification in the therapeutic process. *The International Journal of Psychoanalysis*, 47(1), 26-31.

Maltsberger, J. T. (1984-5). Consultation in a suicidal impasse. *International Journal of Psychoanalytic Psychotherapy*, 10, 131-158.

Maltsberger, J.T., & Buie, D.H. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry*, 30, 625-633.

Maltsberger, J. T., & Buie, D. H., Jr. (1989). Common errors in the management of suicidal patients. In Jacobs, D., & Brown, H. N. (Eds.), *Suicide: Understanding and responding: Harvard Medical School perspectives* (p. 285–294). International Universities Press, Inc.

Maltsberger, J. T., & Goldblatt, M. J. (Eds.). (1996). *Essential papers in psychoanalysis. Essential papers on suicide.* New York: New York University Press.

Manning-Jones, S., de Terte, I., & Stephens, C. (2015). Vicarious posttraumatic growth: A systematic literature review. *International Journal of Wellbeing*, 5(2), 125-139.

Marcinko, D., Skocić, M., Sarić, M., Popović-Knapić, V., Tentor, B., & Rudan, V. (2008). Countertransference in the therapy of suicidal patients - an important part of integrative treatment. *Psychiatria Danubina*, 20(3), 402-405.

Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). *Comprehensive Textbook of Suicidology.* New York: Guilford Press.

Martin, J. M. (2010). Stigma and student mental health in higher education. *Higher Education Research & Development*, 29(3), 259-274.

Meichenbaum, D. (1994). *Treating adults with PTSD.* Clearwater, FL: Institute Press.

Meichenbaum, D. (2001). *Treating individuals with anger-control problems and aggressive behavior.* Clearwater, FL: Institute Press.

Menninger, W.W. (1990). Anxiety in the Psychotherapist. *Bulletin of the Menninger Clinic*, 54, 232-246.

Menninger, W.W. (1991). Patient suicide and its impact on the Psychotherapist. *Bulletin of the Menninger Clinic*, 55, 216-227.

Mental Health Foundation (Undated). *Mental health statistics: children and young people*. Retrieved from https://www.mentalhealth.org.uk/statistics/mental-health-statistics-children-and-young-people.

Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). London: Routledge. (Original work published 1945).

Meyrick, J. (2006). What is Good Qualitative Research? A First Step towards a Comprehensive Approach to Judging Rigour/ Quality. *Journal of Health Psychology*, 11(5), 799-808.

Milton, M. & Crompton, J. (2001). Recent research on suicide issues for British counselling psychologists. *Counselling Psychology Review*, 16(3), 28-33.

Mintz, R.S. (1968). Psychotherapy of the suicidal patient. In: Resnik, H.L.P. (Ed.). *Suicidal behaviors: Diagnosis and Management*. London: Little, Brown and Company.

Misch, D. A. (2003). When a Psychiatry Resident's Patient Commits Suicide: Transference Trials and Tribulations. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 31(3), 459-475.

Modestin, J. (1987). Counter-transference reactions contributing to completed suicide. *British Journal of Medical Psychology*, 60(4), 379-385.
experience and understanding of risk assessment. *Counselling and Psychotherapy Research: Linking research with practice,* 12(3), 214-223.

Moerman, M. (2012). Working with suicidal clients: The person-centred counsellor's experience and understanding of risk assessment. *Counselling and Psychotherapy Research*, 12(3), 214-223.

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/ secondary traumatic stress: A research agenda. *Traumatology,* 23(2), 129-142.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Murphy, A. (2017). *Out of this world: Suicide examined*. London: Karnac Books.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2017). *Suicide by children and young people*. Manchester: University of Manchester. Retrieved from http://documents.manchester.ac.uk/display.aspx?DocID=37566.

Neimeyer, R A., & Bonnelle, K. (1997). The suicide intervention response inventory: a revision and validation. *Death Studies*, 21, 59-81.

Neimeyer, R., Fortner, B. & Melby, D. (2001). Personal and professional factors and suicide intervention skills. *Suicide and Life-Threatening behaviour*, 31(1), 71-82.

Neimeyer, R. A., & MacInnes, W. D. (1981). Assessing paraprofessional competence with the suicide intervention response inventory. *Journal of Counseling Psychology*, 28, 206- 209.

Neimeyer, R. A., & Oppenheimer, B. (1983). Concurrent and predictive validity of the suicide intervention response inventory. *Psychological reports*, 52, 594.

Neimeyer, R. A., & Pfieffer, A. M. (1994a). Evaluation of suicide intervention effectiveness. *Death Studies*, 18, 131-166.

Nelson, L. (2011). Dealing with depressed and dangerous. *Inside Higher Education*, 29 June. Retrieved from www.insidehighered.com/news/2011/06/29/lawyers_discuss _issues_of_suicidal_students_

O'Connor, R.C. (2011). Towards an integrated motivational- volitional of suicidal behaviour. In O'Connor, R.C., Platt, S., & Gordon, J. (Eds.) *International Handbook of Suicide Prevention: Research, Policy and Practice.* Wiley Blackwell.

Office for National Statistics (2018). *Estimating suicide among higher education students, England and Wales: Experimental Statistics*. London: Department of Health. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/ birthsdeathsandmarriages/deaths/articles/estimatingsuicideamonghighereducationstudentsenglandandwalesexperimentalstatistics/2018-06-25.

Oordt, M.S., Jobes, D.A., Fonseca, V.P., & Schmidt, S.M. (2009) Training mental health professionals to assess and manage suicidal behavior: Can provider confidence and

practice behaviors be altered? *Suicide and Life-Threatening Behavior*, 39, 21-32.

Palmer, S. (2007). *Suicide: Strategies and interventions for reduction and prevention.* Abdingdon: Routledge.

Panove, E. E. (1994). *Treating suicidal patients: what therapists feels when their patients makes suicidal threats*. Unpublished PhD, Columbia University, U.S.

Paulson, B.L., & Worth, M. (2002). Counseling for suicide: Client perspectives. *Journal of Counseling and Development,* 80, 86-93.

Pearlman, L.A., & MacIan, P.S. (1995). Vicarious traumatisation: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558-565.

Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: Norton.

Perseius, K.I., Ojehagen, A., Ekdahl, S., Asberg, M., & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using dialectical behavioral therapy: the patients' and the therapists' perceptions. *Archives of Psychiatric Nursing*, 17(5), 218-227.

Phimister, D., & Archer, K. (2008.) Suicide among students. *Mental Health Practice*, 12(1), 20-22.

Phippen, M. (1995, November). The 1993/4 Survey of Counselling services in Further and Higher Education, *Newsletter for Association for Student Counselling*, 25-36.

Pieters, G., De Gucht, V., Joos, G., & De Heyn, E. (2003). Frequency and impact of patient suicide on psychiatric trainees. *European Psychiatry*, 18, 345-349.

Pledge, D.S., Lapan, R.T., Heppner, P.P., Kivlighan, D., & Roehlke, H.J. (1998). Stability and severity of presenting problems at a university counselling centre: A 6-year analysis. *Professional Psychology: Research and Practice*, 29, 386-389.

Pope, K., & Tabachnick, B. (1993). Therapists' anger, hate, fear and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal

complaints, and training. *Professional Psychology: Research and Practice*, 24, 142-152.

Pritchard, C. (1995). *Suicide-The ultimate rejection? A Psycho-Social study.* Buckingham: Open University Press.

Quinlivan, L., Cooper, J., Meehan, D., Longson, D., Potokar, J., Hulme, T., Marsden, J., Brand, F., Lange, K., Riseborough, E., Page, L., Metcalfe, C., Davies, L., O'Connor, R., Hawton, K., Gunnell, D., & Kapur, N. (2017). Predictive accuracy of risk scales following self-harm: Multicentre, prospective cohort study. *British Journal of Psychiatry*, 210(6), 429-436.

Rana, R., Smith, E., & Walkling, J. (1999). *Degrees of disturbance: The new agenda. The impact of increasing levels of psychological disturbance amongst students in higher education.* London: Heads of University Counselling Services.

Reeves, A. (2005). Supporting staff working with suicide. *AUCC Journal*, Autumn, 8-11.

Reeves, A. (2010). *Counselling suicidal clients*. London: Sage

Reeves, A. (2015). Dissemination of research. In Vossler, A., & Moller, N. (Eds), *The Counselling and Psychotherapy Research Handbook.* London: Sage.

Reeves, A. (2018). Working with the risk of suicide. *Therapy today*, Nov 2018 edition, 24-27.

Reeves, A., Bowl, R., Wheeler, S. & Guthrie, E. (2004). The hardest words: Exploring the dialogue of suicide in the counselling process- A discourse analysis. *Counselling and Psychotherapy Research: Linking research with practice*, 4(1), 62-71.

Reeves, A. & Mintz, R. (2001). The experience of counsellors who work with suicidal clients: An exploratory study. *Counselling and Psychotherapy Research*, 1(2), 37-42.

Reeves, A., & Seber, P. (2007). *Working with the suicidal client.* BACP Information Sheet. Lutterworth: BACP.

Reid, K., Flowers, P., and Larkin, M. (2005). Exploring lived experience. *Psychologist*, 18(1), 20-23.

Richards, B. M. (2000). Impact upon therapy and the therapist when working with suicidal patients: Some transference and countertransference aspects. *British Journal of*

Guidance and Counselling, 28(3), 325-337.

Ricoeur, P. (1970). *Freud and philosophy: An essay on interpretation*. New Haven: Yale University Press.

Ricoeur, P. (1996). *The Hermeneutics of Action*. London: Sage.

Roberts, R., Golding., J., Towell., T., Reid.S., Woodford., S., Vetere., A., Weinreb., I. (2000). Mental and physical health in students: the role of economic circumstances. *British Journal of Health Psychology*, 5, 289-297.

Roberts, R., Golding, J., Towell, T. & Weinreb, I. (1999). The effects of economic circumstances on British students' mental and physical health. *Journal of American College Health*, 48, 103-109.

Roberts, R. & Zelenyanszki, C. (2002). Degrees of Debt: In Stanley, N. & Manthorpe, J. (eds). *Students mental health needs: Problems and responses.* London: Jessica Kingsley.

Rossouw, G., Smythe, E., & Greener, P. (2011). Therapists' experience of working with suicidal clients. *Indo-Pacific Journal of Phenomenology*, 11(1), 1-12.

Royal College of Psychiatrists (2011). *Mental Health of Students in Higher Education College Report CR 166*. London: Royal College of Psychiatrists.

Rubenstein, H.J. (2003). Psychotherapists' experiences of patient suicide. *Dissertation Abstracts International: Section B: The Sciences and Engineering,* 63 (9-B), p. 4385.

Rudd, M.D., Jobes, D.A., Joiner, T.E. & King, C. A. (1999). The outpatient treatment of suicidality: An integration of science and recognition of its limitations. *Professional Psychology: Research and Practice*, 30, 437-446.

Samaritans (2018). *Media guidelines for the reporting of suicide*. Retrieved from: www.samaritans.org/media-centre/media-guidelines-reporting-suicide.

Sanders, C. M. (1984). Therapists, too, need to grieve. *Death Education*, 8, 27-35.

Sayburn, A. (2015). *Why medical students' mental health is a taboo subject*. Student BMJ. 350. Retrieved from http://www.student.bmj.com/student/viewarticle.html?id= sbmj.h722.

Scanlon, L., Rowling, L., & Weber, Z. (2010). 'You don't have an identity…you are just lost in a crowd': Forming a student identity in the first-year transition to university. *Journal of Youth Studies*, 10, 223-241.

Schleiermacher, F. (1998). *Hermeneutics and Criticism and other writings* (A. Bowie, Trans.). Cambridge, UK: Cambridge University Press (Original work published 1838).

Schmidt, L. K. (2006). *Understanding Hermeneutics*. Stocksfield: Acumen Publishing Limited.

Schneidman, E. S. (1975). Postvention: The care of the bereaved. In Pasnau, R.O. (ed.) *Consultation-liaison Psychiatry.* New York: Grune and Stratton.

Seguin, M., Bordeleau, V., Drouin, M. S., Castelli-Dransart, D. A., & Giasson, F. (2014). Professionals' reactions following a patient's suicide: Review and future investigation, *Archives of Suicide Research*, 18, 340-362.

Slimak, R. E. (1990). Suicide and the American college and university: A review of the literature. *Journal of College Student Psychotherapy*, 4(3-4), 5-24.

Smith, J.A. (1997). Developing theory from case studies: self-reconstruction and the transition to motherhood. In Hayes, N. (ed.) *Doing Qualitative Analysis in Psychology,* Hove: Psychology Press.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, 39-54.

Smith, J.A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative studies on Health and Well-being*, 2, 3-11.

Smith, J.A. (2010). *Evaluating the contribution of interpretative phenomenological analysis to health psychology.* Keynote address presented at BPS Health Psychology Annual Conference, Aston, UK.

Smith, J.A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9–27.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis:*

Theory, method and research. London: Sage.

Smith, J.A., & Osborn, M. (2003). Interpretive phenomenological analysis. In Smith, J.A. (Ed.) *Qualitative psychology: A practical guide to research methods* (pp. 51-80). London: Sage.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995). Intake interviewing in the suicidal patients: A systematic approach. *Professional Psychology: Research and Practice*, 26, 41-47.

Stanley, N., Mallon, S., Bell, J., Hilton, S., & Manthorpe, J. (2007). *Responses and Prevention in student suicide.* Preston: University of Central Lancashire. Retrieved from http://www.rapss.org.uk/pdf/rapss_full.pdf.

Stanley, N., Mallon, S., Bell, J., & Manthorpe, J. (2009). Trapped in transition: findings from a UK study of student suicide. *British Journal of Guidance & Counselling*, 37(4), 419-433.

Stanley, N. & Manthorpe, J. (2001a). Responding to students' mental health needs: Impermeable systems and diverse users, *Journal of Mental Health*, 10(1), 41-52.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review*, 13, 593-618.

Sussman, M. B. (ed.) (1995). *A perilous calling: The hazards of psychotherapy practice.* New York: John Wiley & Sons.

Tappan, M. (1997) Language, culture and moral development: A Vygotskian perspective. *Developmental Review*, 17, 78-100.

Tarren, S. (2016). Managing demand and surviving the work. In Mair, D. (ed). *Short-term Counselling in Higher Education*. Oxon: Routledge.

Taylor, C. (1985). *Human agency and language: Philosophical papers.* Cambridge: Cambridge University Press.

Tedeschi, R.G. & Calhoun, L.G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.

Tedeschi, R.G. & Calhoun, L.G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455-471.

Tedeschi, R.G., Park, C.L. & Calhoun, L.G. (Eds.) (1998). *Posttraumatic growth: Positive change in the aftermath of crisis.* Mahwah, NJ: Lawrence Erlbaum Associates.

Thongbanthum, A. (2015). *You'll have the best time of your life at uni, it's all downhill after*. The Tab. Retrieved from http://www.thetab.com/uk/birmingham/2015/05/13/uni-days-best-days-life-19098.

Thorley, C. (2017). *Not by Degrees: Improving student mental health in the UK's universities.* Institute for Public Policy Research (IPPR). London: IPPR. Available at http://www.ippr.org/research/publications/not-by-degrees.

Tillman, J. (2006). When a patient commits suicide: An empirical study of psychoanalytic clinicians. *International Journal of Psychoanalysis*, 87(1), 159-177.

Tinklin, T., Riddell, S., & Wilson, A. (2005). Support for students with mental health difficulties in higher education: the students' perspective. *British Journal of Guidance & Counselling*, 33(4), 495-512.

Tracy, S. J. (2010) Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, 16(10), 837-851.

Trimble, L., Jackson, K. & Harvey, D. (2000). Client suicidal behaviour: impact, interventions, and implications for psychologists. *Australian Psychologist*, 35(3), 227-232.

Triplett, K.N., Tedeschi, R.G., Cann, A., Calhoun, L.G. & Reeve, C.L. (2012). Posttraumatic growth, meaning in life, and life satisfaction in response to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy,* 4(4), 400-410.

Trippany, R. L., White Kress, V. E. & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development,* 82(1), 31-37.

UK Council for Psychotherapy (2019). *Code of Ethics and Professional Practice*. London: UKCP. Retrieved from https://www.psychotherapy.org.uk/wp-content/uploads/2019/06/UKCP-Code-of-Ethics-and-Professional-Practice-2019.pdf.

Universities UK (2002). *Reducing the risk of student suicide: Issues and Responsibilities for Higher Education Institutions.* London: Universities UK.

Universities UK (2017) *#stepchange: Mental health in higher education*. Retrieved from https://www.universitiesuk.ac.uk/stepchange.

Universities UK (2018). *Minding our future*. Retrieved from https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/minding-our-future-starting-conversation-student-mental-health.pdf.

Universities UK & Papyrus (2018). *Suicide-Safer Universities*. Available: https://www.universitiesuk.ac.uk/policy-and- analysis/reports/Documents/2018/guidance-for-sector-practitioners-on-preventing-student-suicides.PDF.

Universities UK (UUK) & Standing Committee of Principals (SCOP) (2002b). *Reducing the risk of student suicide: issues and responses for higher education institutions.* London: Universities UK.

Valente, S. M. (1994). Psychotherapist reactions to the suicide of a patient. *American Journal of Orthopsychiatry,* 64(4), 614-621.

VandeCreek, L., & Knapp, S. (1989). *Tarasoff and beyond: Legal and clinical considerations in the treatment of life-endangering patients.* Sarasota, Fl: Professional Resource Exchange.

Waller, R., Mahmood, T., Gandi, R., Delves, S., Humphreys, N. & Smith, D. (2005). Student mental health: how can psychiatrists better support the work of university medical centres and university counselling services? *British Journal of Guidance and Counselling*, 33(1), 117-128.

Webb, N.B. (1986). Before and after suicide: a preventative outreach program for colleges. *Suicide and Life-threatening Behaviour*, 16(4), 469-480.

Weinberg, I., Ronningstam, E., Goldblatt, M. J., Schechter, M., Wheelis, J., & Maltsberger, J. T. (2010). Strategies in treatment of suicidality: Identification of common and treatment-specific interventions in empirically supported treatment manuals. *Journal of Clinical Psychiatry*, 71, 699-706.

Weiner, K. M. (2005). Introduction: The professional is personal. In Weiner, K. (Ed.), *Therapeutic and legal issues for therapists who have survived a client suicide: Breaking the silence*. New York: Haworth Press.

Werth, J. L., & Liddle, B. (1994). Psychotherapists' attitudes toward suicide. *Psychotherapy*, 31(3), 440-448.

Westefeld, J.S., Range, L. M., Rogers, J.R., Maples, M.R., Bromley, J. L., & Alcorn, J. (2000). Suicide: An Overview. *The Counseling Psychologist*, 28(4), 445-510.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3rd ed.). Maidenhead: Open University Press.

Winter, D., Bradshaw, S., Bunn, F., & Wellsted, D. (2009). *Counselling and Psychotherapy for the prevention of suicide: A systematic review of the evidence*. Lutterworth: BACP.

Woolfe, R, Strawbridge, S., Douglas, B., & Dryden, W. (2009) *Handbook of Counselling Psychology* (3rd Ed). London: Sage.

World Health Organization (WHO) (2014) *Preventing suicide: A global imperative.*

World Health Organization (2018). *Global Health Estimates 2016: Deaths by cause, age, sex, by country and by region, 2000-2016*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

Yager, J., & Feinstein, R. E. (2017). A common-factors approach to psychotherapy with chronically suicidal patients: Wrestling with the angel of death. *Psychiatry: Interpersonal & Biological Processes*, 80(3), 207-220.

Yakunina, E. S., Rogers, J. R., Waehler, C. A., & Werth, J. L. (2010). College students' intentions to seek help for suicidal ideation: Accounting for the help-negation effect. *Suicide and Life-Threatening Behavior,* 40(5), 438-450.

Yan, Z., & Fan, W. (2010). Factors affecting response rates of the web survey: A systematic review. *Computers in Human Behaviors*, 26, 132-139.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In Smith, J.A. (Ed.), *Qualitative psychology: A practical guide to methods* (2nd ed). London: Sage.

Yaseen, Z. S., Briggs, J., Kopeykina, I., Orchard, K. M., Silberlicht, J., Bhingradia, H., & Galynker, I. I. (2013). Distinctive emotional responses of clinicians to suicide-attempting patients-a comparative study. *BMC Psychiatry*, 13, 230. Retrieved from http://www.biomedcentral.com/1471-244X/13/230.

YouGov (2016, August 9). *One in four students suffer from mental health problems*. Retrieved from http://yougov.co.uk/news/2016/08/09/quarter-britains-students-are-afflicted-mental-hea/.

Table of Figures

Figure 1: Number of higher education student suicides by year……..35

Figure 2: Rate of student suicide by gender……..……..36

Figure 3: Press articles on suicide in Higher Education…….....41

Glossary of Terms

BACP	British Association for Counselling and Psychotherapy
BACP:UC	British Association for Counselling and Psychotherapy: Universities and Colleges Division
BPS	British Psychological Society
CoP	Counselling Psychology/Counselling Psychologist
DCoP	Division of Counselling Psychology (of the British Psychological Society)
DH	Department of Health
HE	Higher Education
HEIs	Higher Education Institutions
HUCS	Heads of University Counselling Services
IPA	Interpretative Phenomenological Analysis
IPPR	Institute for Public Policy Research
MDT	Multi-Disciplinary Team
NCISH	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
NHS	National Health Service
ONS	Office for National Statistics
RAPSS	Response and Prevention in Student Suicide
RCP	Royal College of Psychiatrists
SCOP	Standing Committee of Principals
UK	United Kingdom
UKCP	UK Council for Psychotherapy
UUK	Universities UK
VT	Vicarious Trauma
WHO	World Health Organisation

Appendices

Appendix 1: Literature search strategy
Appendix 2: Recruitment advertisement for interview participants
Appendix 3: Participant Information Sheet (PIS)
Appendix 4: Email sent to potential participants
Appendix 5: Description of university types
Appendix 6: Interview schedule
Appendix 7: Interview introductory guidelines
Appendix 8: Ethical approval letter
Appendix 9: Consent form
Appendix 10: Data Analysis- Sample of analysed transcript
Appendix 11: Data Analysis- Sample of emergent themes
Appendix 12: Data Analysis- Sample of themes across participants
Appendix 13: Dissemination Activity 1- HUCS survey design
Appendix 14: Dissemination Activity 1- Survey for HUCS members
Appendix 15: Dissemination Activity 1- Recruitment email for HUCS survey
Appendix 16: Dissemination Activity 1- HUCS survey findings
Appendix 17: Dissemination Activity 2- Presentation notes

Appendix 1: Literature Search Strategy

Initially, I searched the Middlesex University Research Database which gave me access to various electronic academic literature databases such as PsychINFO, PsychARTICLES and Psychology and Behavioural Sciences Collection (PBSC) databases. I then used other search strategies included the British Library database, and Internet search engine, Google Scholar. Mostly, sources arose from a snowballing effect as a result of my reading, general internet searches, and from conversations with colleagues. Reference lists of each article were also searched by hand, in order to identify articles that might have been missed in the original search and which might have been relevant to the topic of interest. Finally, I referred to policy documents and articles which I had access to, as part of my membership to the Universities Mental Health Advisers Network, in my former role.

When completing a literature search, establishing the boundaries of the review was the most challenging aspect of this process. Due to the vast amounts of literature available on suicide, I was very selective about the terminology that I used in my database searches and used the following key words:

- Therapist OR Psychologist OR Counsellor OR Psychotherapist OR Psycho* OR Counsel* OR Therap*
- Suicide OR Suicid*
- Experiences OR Attitudes OR Responses
- Student OR University OR College
- Organi* OR Team approaches
- Vicarious trauma OR Traum* Or Burnout OR Stress

Similar keywords were combined using 'OR', as shown above. Groups of keywords were then combined using 'AND' to form a variation of searches. For example, when searching for literature on *organisational experiences of suicide*, I used the following combination of groups of keywords:

- Organi* OR Team approaches
  AND
- Experiences OR Attitudes OR Responses
  AND
- Suicide OR Suicid*

Some search terms, such as self-harm and self-injury were excluded from my search as they generated a large number of irrelevant articles.

I also changed elements of my search, when I was unable to gather relevant information during my earlier searches. For example, I initially wished to explore research undertaken in the U.K. only, however this did not yield a large amount of relevant data, so I excluded the keyword, U.K. from my search, in order to include international research on the topic under study. I was also mindful of publication dates; given that the higher education system in the UK had changed considerably in the past 30 years, I was mainly interested in exploring research on student counselling which spanned this period. The only limit that I imposed on the search options was that the articles needed to be available in the 'English language'.

Where possible, I focused mainly on primary sources with only a selective use of secondary sources. Apart from noting an increase in contemporary literatures in the form of populist articles on suicide from major press sources in recent years, unfortunately, only a very small number of research papers and books which were relevant to my research question, were located.

Appendix 2: Recruitment Advertisement for Interview Participants

CALLING ALL THERAPISTS WORKING IN HIGHER EDUCATION

An exploration of therapists' experiences of working with suicidal students in Higher Education

Are you a Therapist working in Higher Education, with over 5 years' experience of working therapeutically with suicidal students? If so, would you be willing to explore your experiences further and make a valuable contribution to this study?

You must be registered with BACP, BABCP, BPS or UKCP in order to participate in this study (please refer to suitability criteria attached for more information). The study will require participation in a 1 - 1.5 hour interview. Participants' wellbeing will be at the forefront of this study and all issues discussed will be treated with respect and sensitivity, and confidentiality will be guaranteed. Ethical approval for this study has been granted by the Metanoia Institute, London.

A Participation Information Sheet is attached for further information about the study. If you wish to register your interest, or have any questions, please email XXXXXXXX.

Appendix 3: Participant Information Sheet (PIS)

An exploration of therapists' experiences of working with suicidal students in Higher Education

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to contact me directly if there is anything that is not clear, or if you would like more information about this study.

Thank you for reading this.

What is the purpose of the study?
A report published by the Royal College of Psychiatrists in 2011 stated that suicide risk amongst the student population is an increasing concern amongst mental health professionals working in Higher Education Institutions (HEIs). Despite this recommendation, research on therapists' experiences of working with suicidal clients in student counselling services is an area which has been largely neglected. With the concept of life-long learning firmly embedded in the minds of society and given the increase in mental distress and increase in suicides amongst students, research on mental health professionals working with this complex population is imperative.

This study aims to address the significant gap in research on working with student suicidality in HEIs within the UK by exploring therapists' experiences of working with suicidal students in higher education institutions. It is hoped that the findings may, in turn, assist HEIs in planning improvements to their services for students and staff in the future and it is anticipated that the study will be completed by May 2018.

Why have I been chosen?
You have been chosen as you responded to my advert listed on the university mail database and were selected as you are a therapist who works directly with suicidal students in a higher education institution.

There will be approximately up to 9 participants used for this study.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form.

If you decide to take part you can withdraw from the study up to the point where the analysis of the data has been completed, as it would be difficult to separate each individual's comments at that stage. It is anticipated this will be May 2018.

What will happen to me if I take part?
For this study, I aim to collect information to answer the research question through the use of semi- structured interviews.

As a participant, you will be requested to attend an interview on one occasion with the researcher. If you give consent to take part, the interview will last between 1- 1.5 hours. All interviews will be audio recorded and transcribed. You will be sent a copy of the transcribed recorded interview to check and verify at a later date.

What are possible benefits of taking part?
We hope that participating in the study may be beneficial to you in your work with suicidal students. However, this cannot be guaranteed. The information we get from this study may help us to provide better support for therapists working in higher education, and possibly improve service provision for students in the future.

What are possible disadvantages and risks of taking part?
It is accepted that suicide is a sensitive subject which can evoke some powerful emotions. In light of this, it is possible that you may experience some psychological distress as a result of taking part in this study. If so, I will ensure that you have all of the information in order to seek further support for yourself, should you need it.

Will my taking part in this study be kept confidential?
All information that is collected about you and the institution in which you work during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with the Data Protection legislation of the UK.

What will happen to the results of the research study?
This research will be published as part of a postgraduate thesis in May 2018 and a copy of the published results can be obtained from emailing the researcher at XXXXXXX.

Who has reviewed the study?
This study has been reviewed by the Metanoia Research Ethics Committee and ethics approval has been granted.

Contact for further information:
Student XXXXXXXXXX
Supervisor XXXXXXXXXX

Thank you for taking part in this study!

Date:

Version number

You will be given a copy of the information sheet and a signed consent form to keep.

Appendix 4: Email sent to Potential Participants

Dear ……

Thank you for registering your interest in this study.

Firstly, I would just like to check if you meet the requirements for the study and have included an outline of the criteria below for your information.

Inclusion criteria

- therapists currently working in any Higher Education Institution within the UK
- therapists with 5 years or more post- qualifying experience
- therapists with accreditation by the British Psychological Society (BPS), British Association of Counselling and Psychotherapy (BACP) or UK Council for Psychotherapy (UKCP)
- therapists who currently see, or have seen in the last year, students they believed to be suicidal
- therapists with clinical supervision in place
- therapists who can gain access to therapy easily, if deemed necessary

Exclusion criteria

- trainee therapists
- therapists with management responsibilities (e.g. Head of Counselling or Senior Counsellor positions)

If you meet the criteria, and are still interested in participating in the study, I am very happy to arrange a time to meet with you. As I mentioned in the advertisement, your participation will require attending an interview of up to 1- 1.5 hours at your university. Please do let me know your availability so that we can arrange to meet at a time that is convenient for you. Also, I would be very grateful if you could book a confidential space for our meeting, preferably a space that is separate from your workspace and/or service.

I have attached a copy of the Participation Information Sheet, however, please do feel free to contact me if you have any further questions about the study at this stage. I am happy to answer any questions by email or phone.

I look forward to hearing from you shortly.

Warm regards

XXXXXXXXXXX

Appendix 5: Description of University Types

Russell Group

Established in 1994, The Russell Group is an organisation of 24 prestigious British universities that are often regarded as the ‘best’ in the UK. Its members consist of mainly the ancient universities and 19th century universities, with a few of the larger civic universities. They are committed to industry-leading research and an outstanding learning experience for all students, and as such, their commitment ensures they get the majority of funding from the UK government, with over two-thirds of university research funding awarded by the British government. Such finding allows them to continue to drive innovation and produce high-level graduates. Their substantial research income reduces their reliance on tuition fees and makes them more financially secure. In recent years the title 'Russell Group' has been used as a marketing brand to suggest that these Universities are more 'elite' than others

Pre-1992 universities

Pre- 1992 universities, made up of ‘plate glass’ universities, are institutions that were given royal charter between 1963 and 1992 (mainly in the 1960s) as part of education reforms to increase the number of universities in the UK. They were also often referred to as 'campus universities' as most of them were built on designated green-field sites as self-contained US style campuses. Pre-1992 universities are typically more research-intensive and continue to focus their teaching on academic courses.

Post-1992 Universities

Post-1992 universities, also known as ‘new universities’ or ‘modern universities’, refer to the former polytechnics, central institutions or colleges of higher education that were given university status by John Major’s government in 1992 (through the Further and Higher Education Act 1992) as well as an institution that has been granted university status since 1992 without receiving a royal charter. As former polytechnics or teacher training colleges, they are typically less research-intensive, and offer a wider range of vocational courses. This distinction is, however, becoming less clear in the 21st century, with the arrival of substantial numbers of new universities.

Appendix 6: Interview Schedule

CLINICAL PRACTICE

1
Can you provide some background/context to your work with suicidal students please?
Prompts:
When did you initially start working with suicidal students?
How long have you been in your current post?
Do you work individually or as part of a wider team?
Did your therapy training prepare you for your work with suicidal students, and how?
How did it feel working with suicide as a theme with that client population, at that given time?

2
If a student tells you they have active plans to end their life, what initial feelings does this bring up for you, and do these feelings change over time? If so, in what way do they change, and what might influence that change?

3
How willing are you to explore a student's suicidal thoughts in depth, and how do you envisage your role as a Therapist in supporting suicidal students?

4
Are there any particular issues you pay greater attention to when working with suicidal students, and if so, why?

5
Have you ever worked with a student who attempted or completed suicide during your work together? If so, can you describe how it impacted you professionally and personally?
Prompts:
What happened?
How did you feel?
How did you manage the situation/ your feelings/ behaviour?
*What was it like working with this student before **and** after their attempt?*

6
What has supported or facilitated your work with suicidal students, and in what way has it helped you? *This may include personal or organisational issues.*
Prompts:
Tools for risk assessment, supervision, risk protocols, management support, clarity of professional responsibilities

7
What challenges or limitations have you faced in working with suicidal students, and how have you managed those challenges? *This may include personal or organisational issues.*

Prompts:
What has hindered your work with suicidal students?
What have you struggled with in relation to your work with suicidal students?
E.g. training, resources, service provision, risk protocols, management expectations?

8
How has working with suicidal students impacted your overall clinical practice, and have you changed the way you work with suicidal students over time?
Prompts:
Has it changed how you feel about your practice as a Therapist?
Do you view yourself differently since working with suicidal students? If so, in what way has your perception changed?
e.g. are you more/less confident working with suicidal students? How do you feel about those changes?

9
How do you attend to your self-care when working with suicidal students?
Prompts:
What helps?
Who do you speak to?
Can you recognise when you need support?
Is there anything you wish to do more of to improve your self-care?

STUDENTS

1
What are the challenges (or concerns) of working with this specific client group, in your opinion, particularly where suicidality is concerned?
Prompts:
E.g. concerns re: international students, developmental stage, transitional phase, displacement, cultural issues, academic pressures

2
How has working with suicidal students compared with other client groups you have worked with in the past?
Prompts:
How have you felt about working with the student population in general?

ORGANISATIONAL ISSUES

1
What is your experience of talking about suicide or suicidal students, with your colleagues or during your team meetings?

2
How does the current climate in H.E influence your work with suicidal students, if at all?
Prompts:

E.g. increase in suicides, fee changes, increasing demands for counselling provision and service pressures

SELF

1
What personal factors have shaped or influenced how you work with suicidal students?
Prompts:
E.g. Religious beliefs, cultural attitudes, experience of familial suicide, personal history, life philosophy etc.

2
What impact has working with suicidal students had on you personally, that is, your world view and/or your relationships with others?
Prompts:
E.g. Relationships with students, supervisor, colleagues, manager, family, and friends?

WRAP UP

1
Is there anything you wish to add in regard to your experiences of working with suicidal students which has not yet been explored today?

2
Are there any issues that you will take away and give greater consideration to, as a result of attending this interview today? What do you think might help you improve your work with suicidal students in the future?

3
Do you feel that further research needs to be done in this area? If so, which area/s warrants further attention and why?

CLOSE

Discuss post interview plans (checking transcript) with participant and check participant's contact details

Any additional questions from the participant?

Thank participant for their time

Appendix 7: Interview Introductory Guidelines

1. Introduce my role, background and context of study

2. Important information about the interview process:

- *Audio recording of the interview- check consent again?*
- *Length of the interview – Between 1- 1.5 hours*
- *Setting- confirm it is a confidential space?*
- *Anonymity – use of pseudonyms*
- *Right to withdraw at any point, if necessary & reminder to seek support, if necessary*
- *Post-interview procedures and expected completion date of the research*

3. General guidelines for the participant:

- *Please take as much time you need to think about your responses. You can give as much (or little) detail as you wish*
- *I am interested in your experiences. I might also ask questions which appear to be self- evident- this is because I want to grasp* ***your*** *understanding/ interpretation of ideas, events' etc.*
- *There are no rights or wrong answers*
- *Gain written consent to participate in the study*

Appendix 8: Ethical Approval Letter

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

XXXXXXXX
DCPsych programme
Metanoia Institute

29th July 2016

Ref: *6/15-16*

Dear XXXXXX

Re: An exploration of therapists' experiences of working with suicidal students in Higher Education

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Institute Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Institute Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Subject Specialist (Research), DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Appendix 9: Consent Form

Participant Identification Number:

Title of Project: An exploration of therapists' experiences of working with suicidal students in Higher Education

Name of Researcher: XXXXXXXXX

Please tick box

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions	☐
I understand that my participation is voluntary and that I am free to withdraw at any time up to the point of the completion of the analysis of the data, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided	☐
I understand that my interview will be taped and subsequently transcribed	☐
I agree to take part in the above study	☐
I agree that this form that bears my name and signature may be seen by a designated auditor	☐
I agree for my contributions to be used anonymously as part of the data analysis and presented in the final thesis and in future publications.	☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Researcher Date Signature

1 copy for Participant; 1 copy for Researcher

Appendix 10: Sample of an Analysed Transcript

Example 1:

Highlighted in yellow= verbatim illustrating important emergent themes

Emergent themes	Transcript	Exploratory comments/ notes
Importance of supervision Need for familiarity Grounding Safety comes from structure	**INT: So thinking more, I guess maybe more broadly, what do you think facilitates your role, what facilitates or supports your work with suicidal students?** RES: Right, supports... **INT: And also and how, and so it could be something that's quite personal, or it could be something organisational, sort of thinking on a bigger, wider scale?** RES: I mean starting from perhaps the outside, I mean obviously supervision is essential, I mean my supervisor is there and I can talk to her about concerns and they're there, absolutely essential. The organisation, if I have had a heavy session and I tend to come out and seek a colleague, not necessarily even to talk about the session, but just somebody who I know has gone through something similar themselves and can say 'yeah, are you okay?', just get a bit of normality into that, and then maybe the kind of biscuit and cup of coffee or something, kind of just grounding. Quite often it would be, I mean particularly a heavy meeting or concern, is knowing that there is a structure, so it might mean talking to a manager and saying 'I'm really concerned about this student, this, this and this', and contacting the mental health advisors and co-ordinators when they're in the right situations and saying 'look I'm concerned about this student', depending I mean if it was seriously suicidal we probably already would have some kind of rapport going on, and then kind of discussing is there any need to do some monitoring or some more looking at the situation. At times with the students permission, I have liaised with GPs and other professionals…they have been the university psychiatrist, obviously all of this is with the client's permission, so that might be, but if it was just, if it had been a heavy session but I	Supervisor is vital Need for sameness Need for comfort and grounding Importance of structure within organisation Reaching out to colleagues for support Freedom to voice concerns Establishing action plan Liaison with services/ colleagues

Internal supervisor Focus on doing Writing clarifies thinking Personal self-care strategies Need for switching off from thinking	didn't feel there was any increased risk or anything like that, perhaps it would just be a little time for myself, having aired myself a bit having had a conversation with a colleague, just checking with myself that I'd done what needed to be done. I think there is a kind of, I think we all build up in the end, some kind of internal supervisor, against which we check, are there any concerns, are there any alarm bells ringing, could I have said something, is there something perhaps I need to make a note of for next time, are there any things, okay right fine, that can now be left until next time. Writing the notes is sometimes also quite an important thing because I find that writing the notes; something pops to mind and clarifies the situation even further, so I think that it's not wasted time. And then I think it's really important for me to have a life outside of work, I enjoy my family and cats…. I think cats are very good for counsellors and having other interests other than constantly thinking about people and their behaviour and their thoughts and their feelings.	Checking in with self Mental checklist? Use of internal supervisor Importance of note writing to clarify actions/thinking? Self-care Cats as self-care Getting out of your head/Switching off
	INT: So a way of kind of switching off from that? RES: Yeah absolutely.	
Difficulty in detaching from work	**INT: That sounds really important.** RES: It is really important, coming out of it, spending time with friends, I think we all have our own particular interests, I mean I'm interested in reading and the theatre and films and things like that, so I kind of enjoy doing those kinds of things in my free time, and I mean I think they do also mean you start thinking about all the people that you see in the play and their characters and things, but you're off duty then.	Theatre, reading-self-care Work projected into free time? Carry the students into personal life?
	INT: I guess maybe what you're describing then is your way of I guess self-care? RES: Yes.	
Importance of relationship with manager Managerial role of holding risk	**INT: Of when you're working with particularly high-risk students.** RES: And I think where it can break down is if you don't have a supportive working environment, I mean what's really essential is that you have a good relationship with your manager and you can report any kind of issues, and they hold the risk, the service, and obviously that you have clear networks, where	Need supportive environment- work is destabilising? Relationship with manager Manager holding risk

Crisis management	to go if you have particular risk issues, if the risk increases to an amount that something needs to be taken, some action needs to, I need to be able to know what I do, so if I'm a lone practitioner which I have been at times, I know that the person that I can contact is the psychiatrist for the organisation or the client's GP.	Need input from manager to know what to do Need for clarity
Importance of clarity from policy	**INT: So is that part of your policy then, your institutional policy?** RES: Yes I mean that certainly is my policy, I need to know where I'd go with things, what my reporting line is as it were.	Importance of reporting line Need a clear policy for managing a crisis
	INT: And is that clearly stated within your role, so the guidelines around working with suicidal students? RES: Usually yes, I mean in all the organisations that I have been, I think they may not have started like that but in the end, there has been a clear structure, protocol yes, of how things are done.	Policy – produced reactively? Need for clear protocol to aid work
Clear protocol aids therapy work	**INT: Right okay, and do you think then that aids you in your work?** RES: Yes I think that aids my work because I know, because it is something about, I mean I have been in situations where there have been questions, where colleagues have come from other institutions have said 'well I got into trouble because I didn't act on this but I didn't know who to tell and I didn't know what I should have done', and it gets very difficult if somebody doesn't know when they should report something or who is ultimately holding the risk, what the procedures are. I think it makes it even more difficult, and it makes the pressure and the stress harder.	Lack of understanding of protocol Lack of clear policy leads to increased pressure and stress
Stress increase from lack of clarity		
Fear Shame? Exposure	**INT: On the individual practice?** RES: Yeah, and it's going to burst out somewhere before too long, that's my fear.	Mounting pressure on therapist? Explode???
	INT: Right, what would happen? RES: Well if…I'm just thinking about if a practitioner worked with a client and didn't feel that they could talk to anyone about that, and then something happened and the student killed themselves or ended up in hospital with a serious suicide attempt, the question could be asked 'well why didn't you tell anyone?' or 'what did the institution do about that?' and I think the practitioner could be at risk of being accused of not doing their job properly	
Scrutiny from the institution Question over therapist competency		Public scrutiny Backlash from institution Fear Reprimanded

Institutional self-protection Institutional blame Therapist insecurity Therapist withdrawal/ avoidance due to competency concerns Therapist isolation	because they hadn't informed or they hadn't communicated, because my sense is that institutions want to protect themselves and they want to see that everything had been done, and if management then weren't aware or weren't approachable enough, they might put the blame on the individual and say 'well you should have done something about this, you should have told us, you should not have carried this on your own'. **INT: And how do you think then that that, them wanting to protect themselves, blaming, I'm just wondering how do you think that might, does that feed back into the work do you think?** RES: I think if that were the case, oh yes if somebody feels that they are very much on their own and a bit insecure then the work would be affected, I think people should feel so comfortable and supported and safe in their work I think, and I think the tendency could be to try and shy away from asking too direct questions about risk and keep that a bit vague because there would be 'how do I deal with that then if I haven't got the support?'. **INT: So it might affect the degree to which you might explore suicidal thoughts...** RES: Yeah, now as I said I'm in the happy position that that has not happened to me, but I could see that in a situation like that it could happen, and I do, I have met in the past colleagues who have felt that they have very much been on their own in situations, and perhaps grappling with issues like that.	Institutional wish to protect the institution Box ticking exercise Institutional blame on therapist Accusations Feeling isolated Speaking in third person? Why? Self doubt? Expect comfort/ safety in workplace Avoid asking about risk due to lack of support Anger over lack of support? Isolation due to lack of support

Example 2:

Emergent themes	Transcript	Exploratory comments/ notes
	INT:….I was just thinking about what your experiences of talking about suicide with your colleagues was, whether that's in a team meeting setting, kind of thinking about as a group how you manage that, what is your experience of the group managing that?	

Sharing concerns Sharing is holding Sharing improves team response Need to justify actions Suicide is unlucky Reluctance to engage with suicide Suicide is intolerable Adequate support for therapists?	RES: I mean I think it's good if we have an opportunity to discuss our concerns about suicidal students, I mean I've been in organisations where we've done that and we've talked about our concerns and shared them, and there's been that kind of sense of holding, because I think that's really, really helpful, and that I'm not on my own and my colleagues are not on their own, and so if say I'm away and somebody comes and needs to talk and colleagues know that this is one of those suicidal students that I see, then they know what to do and they can be there, and it's also something about reassurance, that if I've spoken and we've all kind of said our bit, then there's the kind of agreement that we have done what we can, and so if anything should happen we kind of feel that we've done the right things. It's also something about, I mean I haven't been in a situation where there's been a suicide and we need to consider that and have a debriefing of that, lucky me, but there is something about being able to talk about the potential. **INT: And is that something that you, do you think there's been open spaces for that?** RES: To an extent, I think it's a very difficult one because I think whenever there's a suicide people tend to first think 'thank goodness it wasn't somebody who has been to see us' or 'thank goodness it was in another institution' or something like that, so there is that kind of thing, I mean I think there's again, going with very practical things, what to do with if that happened and guidelines, but I think we've in the main shied away from thinking about what to do if somebody, if that were to happen. **INT: Shied away?** RES: Yeah, I mean I know that there's been colleagues who have seen students who have ended up in hospital with suicide attempts and it's been really important that it's been discussed and supported, the practitioner has been supported and the team has shared their kind of feelings, and also sometimes the workload because it can happen that suddenly you know, somebody has got three suicidal students and they themselves perhaps have got a terminally ill parent or something like that, so you need to kind of say 'well is this really, can we do something about this, can we make sure that perhaps this person's load is lightened in some way?'	Discussing & sharing concerns is helpful Don't feel alone with it Unity Team communication informs crisis plan Sharing provides reassurance for colleagues Need to cover back? Doing the right thing Expectation of a debriefing post-suicide Lucky me? Relief that student not known to the service? Not our problem? Institutional reluctance to consider prospect of another suicide Support for therapists Lightening the load to ease pressure

Shared responsibility for practitioner self-care	**INT: Is that the question that you ask yourself or is that something that is shared with the team?** RES: It's shared yeah. **INT: So, your experience is that people will think about the bigger picture for that practitioner?** RES: Absolutely, and I remember, again a colleague, again I can't, he was sort of rushing around looking after his suicidal students and saying 'well yeah but I haven't got time to come to supervision because I've got to do this' and I said 'but supervision is there so that you can talk about this', and he sort of stopped and I said 'look, this person left that message for you last night, the fact that you don't get back to them at 9 o'clock in the morning doesn't mean that you've abandoned them, come to supervision or whatever team meeting it was, and let's talk about it, and then you can get back to them', and he did come into the meeting and he spoke and afterwards said 'that was so helpful, thank you for pushing me to come in there', so I think it's important to do those kinds of things, for all of us to support one another, and I know that I've been supported when I've talked about my suicidal students and my concerns, and even just somebody saying 'did you do that, did you do that, did you do that, does so and so know, does so and so, do they have this? Okay well what else could you have done?'. **INT: So there is something for you about sort of being able to have a checklist or something?** RES: Yeah and it's not even just a checklist, it's somebody saying 'yeah you've done what you can', it's that person and hearing, and the colleagues and the team saying 'yeah, none of us would have done anymore, we agree you've done what was needed', so something about kind of- **INT: Validation?** RES: Yeah, and that kind of, yeah validation and support, agreement that this is what it takes. **INT: I was actually just thinking about sort of the validation and how that might work with working with suicidal students, whether**	Shared responsibility for practitioner self-care Taking care of each other Talking about risk concerns is purpose of supervision Therapist fear of abandoning students Benefits of supervision Support from colleagues is crucial Sharing provides validation Validation from others is important
Benefits of s/v Importance of peer support Need for validation from others Needing others to be in agreement with interventions		

	perhaps validation is more important for those students than other students?	
Validation important for suicidal students Need to 'get it right'	RES: Well it's more important to know that...yeah in some ways there is that sense that it's more important that other people recognise what I'm doing with them, because it can have consequences and obviously we all make mistakes, but it's kind of more important that I don't make mistakes or huge mistakes with those students than with some of the others, because again it's the being there and making sure that I'm alert and able to deal with whatever comes from them.	Importance of others validation Suicide has serious consequences Unable to make mistakes with suicidal students Need for alertness
Heightened attention	**INT: So is there a sort of sense of being aware of not wanting to make a mistake?** RES: Definitely, definitely. And in some ways, I think it's helped by the fact that it is so intense anyway, that I am constantly kind of pinned into, and my sort of senses are heightened and there is that sense that everything is kind of on contact mode, eyes, ears, everything is there kind of picking up anything that comes out.	Intensity of the work Heightened senses Pressure to pick up cues?
Unconscious processes-tiredness	**INT: Fully alert, that's what comes to mind when you're talking.** RES: Yeah. And that's where the tiredness comes then, when a person has gone because everything is kind of, everything has been so kind of voiced in the room.	Alertness leads to tiredness Energy required Explicit communication
Institutional responsibilities/ duty of care	**INT: I was actually just thinking about the current climate in higher education really, and whether you think that might impact your work with the suicidal students, if at all?** RES: Yes I think the current climate does affect all students because there is that sort of real need, it's important not just to get a good degree, you have to get a first or at least a 2:1, and if you can, you should go and do a Masters because now a first degree is not valued as high enough, and with all the funding issues and things, they take huge loans or you have to make sure that you get the funding from parents, and of course with international students they have to keep a certain level of performance in order to maintain their scholarships, and all that adds to the pressure you know, obviously institutions have realised that they too must monitor and make sure that they are doing their bit, they're having to make sure that they are valued highly so that staff are doing their own research and such like, so	Interviewer moves to new question- quickly? What is going on unconsciously? Academic pressure to succeed Funding difficulties among students Academic pressures on international students Institutional responsibility to do their 'bit' Institutional reputation

Suicide trigger- Parental pressures Pressure higher for current students? Trends in student mental health Fear of disclosures among students	again it kind of effects the contact time. Parents are kind of stressing on to the students that 'you must get a good degree because so much is invested in you', and a lot of the time parents are also subsidising the students' living, whether financially or otherwise, and they may be sort of feeling 'I can't let my family down, I can't waste this money, I can't waste this time, I'm behind my peers because I took a gap year or did something else', there is a tremendous amount of pressure, a tremendous amount of pressure, and sometimes it can then, for anyone who was feeling that way, think there's only one way out, or there might be sort of a sense if you're more vulnerable it somehow can pile up even more than it did in the past. It's also obviously higher education you know, in some ways it has been seen as being a way of improving yourself, so a lot of our people, healthcare professionals have been encouraging people to go to study because then you can get qualification and you can do something with your life, so there's a lot more students with mental health issues, and some of them are reluctant to declare them because they fear that they would be counted against them instead of actually them being able to get some support, so it sometimes takes quite a long time to pick up the students who could really do with mental health support, and guide them to the right places for that, so again I think these students can sometimes be there and struggle with it a bit more, if they ever find a way to get the support that they are entitled to really through the legislation. **INT: So there are lots of factors aren't there?** RES: Yes. **INT: That you think influence your work or influence...** RES: Yes it does influence- **INT: or increase in suicidal risk….** RES: Absolutely.	Parental pressure Increased pressure Suicide is the only option Education as a form of improvement Focus on furthering qualifications Reluctance to declare MH issues Fear of discrimination Fear of discrimination impacts support access

Appendix 11: Sample of Emergent Themes for One Participant

Sample of emergent themes for a participant

Impact of suicide on university staff neglected
Busier services
Institutional anxiety within the institution
Services increasing in size
Therapist role changing over time
Increase in demands for counselling
Efficacy of risk assessment tools
Implicit communication about suicide
Discomfort from 'not knowing'
Need to 'do something' when assessing risk
Confusion around deciphering degree of risk
Powerlessness among therapists
Limited resources in NHS impacts service provision
Increased activity in university following a suicide
Organisational need to be seen to be doing something
University concern about reputation
University staff' perception of counselling role to stop suicide
Unrealistic expectations of counsellors
Pressure on institutions to respond to suicide
Counselling service needs support from institution
Need for a joining up of services
Need for training to increase staff awareness
Pressures on lecturer to manage suicidal students
Perception that we are not doing enough
University staff expectations of a 24-hour service
Identification as a non-crisis service
Confusion over what therapists offer
Importance of a risk policy
Policies create anxiety
Policies provide clarity
Need for consistency in service provision
Value of collaborative reflection
Pressure to turnover
Need for space to breathe
Peer support
Need for validation from others
Fast-moving pace of suicide
Isolation
Need for good self-care
Fear of being punished by institution
Fear of tarnishing university reputation
Lack of clarity around professional responsibilities
Dissociation
Fear of de-sensitisation over time
Usefulness in exploring countertransference responses
Therapist role to help students understand what suicidal means to them
Suicidal thoughts can open up other conversations
Fear of missing something
Lack of external services for those who are suicidal

Reliance on intuition in assessment
Limited by service constraints
Service constraints
Taking anxiety home
Piecing info together between services
Playing Russian Roulette?
Need for improved communication between services
Counsellor providing a missing piece of a jigsaw to the NHS
Fear of miscommunication about risk
Tools provide reassurance
Need to cover your back
Caution about note keeping
High intelligence and positive therapy outcomes
Suicide triggers- comparison with peers
Suicide triggers – unrealistic expectations about university
Healthy to talk about suicide
Importance of normalising suicide
Suicide as an expression of despair
Suicide triggers – Political climate affecting mental health
Suicide triggers – Hopelessness among students
Importance of supervision
Supervision focuses on the therapist's needs
Self-care- speak to husband
Burdensome work
Self-care- Working part time
Self-care- Need to get into the body
Self-care- Reading
Comfort from sharing concerns with colleagues
Need for validation from colleagues
Noticeable more implicit encounters around risk disclosure
Implicit communication creates uncertainty
Need for reassurance
Use of humour as a coping mechanism
Usefulness of talking about suicide arose from personal experience
Constancy of theme of suicide
Greater comfort in talking about suicide over time
Talking about suicide leads to movement and change
Importance of recognising the value of human connection
Future fear of increase in suicides
Organisation duty of care to staff
Need for acknowledgment of emotional impact of suicide on staff
Cultural shifts in HE
Universities as businesses
University concerns with student retention
Conflicting roles

Appendix 12: Sample of Themes Across Participants

Superordinate Theme 1: Exploring suicidality		
Subordinate themes	**Emergent themes**	**Sample of Quotes**
The phenomenon of suicide	Taboo/ stigma of suicide Insidious nature of suicide Complex phenomenon Shame- inducing Burdensome nature Carrying risk/ Holding responsibility for students' life Anxiety-provoking Primal instinct to protect Suicide is intolerable Suicide impedes therapy Powerful impact Dissociative process in suicidality Need to do something Parallel processes- splitting Renders one powerless Impotence Inability to talk about suicide in society Media reporting is irresponsible Power of silence in small communities Willingness to explore suicidality Importance of the suicidal parts of the self being heard	*Suicide stops the possibility of anything ever changing for that person, because all that's changed is they're dead. And that's an end point. It's not a gateway for me. I don't have a belief in another life or an afterlife or I don't have religious belief for me, so for me, it's an end….and that feels really bleak. (Beth)* *Sometimes it's such an obstacle that you can't work therapeutically with the person because they're not really there (Hannah)* *While one wants to do everything one can to minimise it or to work through things so they're not at risk of doing that, risk it seems to me, to be part of the job (Toby)* *I think my first initial reaction is that this is something really quite scary, that it also feels a huge responsibility and of course issues of confidentiality and at what point it might be appropriate to consider sharing information with somebody else (Sue)* *I think, as a society, death is still a taboo, all sorts of death. We don't talk…(Toby)*
Assessing suicide risk	Variety of risk assessment methods Efficacy of risk assessment tools	*I work with it but it's not, I don't feel it adds anything to my work. If anything, it*

	Implicit communication of suicide Assessment vs ongoing therapy- risk indicators differ Silence as a measure of risk Intuition/ sixth sense Mental checklist Increased attunement Heightened attention Focus on here and now Highly alert to non- verbal communication Subtle nuances indicating risk Need for stillness Greater focus on visceral process 'Confusing' process of deciphering degree of risk Burdensome process Asking the suicide question is important	*gets in the way. If a client said they found it useful, then that's a completely different matter, but that's by the by maybe, I don't know. (Toby)* *I'm probably doing a bit of mental checking, 'have I done everything. Have I done this, have I done that? (Nadine)* *I guess I'm thinking it's a particular kind of stillness that I notice myself going into quite a kind of solid grounded place in order to hold the fragmented-ness of the student I guess (Sophie)* *There's – sometimes the – with a, with a student who, who I, who I'm concerned about, sometimes that question is either left blank or it's, or it says zero and – but there's just a sense of flatness or a, a real – you're just kind of picking – just there's something that's telling you that something's not right with a student and those are the really worrying ones.(Cath)* *I think it's also these kinds of risks of finding out the kind of more subtle nuances, and there are, sometimes I get a feeling from a person that there is something more (Helen)*
The impact of working with suicide	Lingering nature of suicide Impacts are long-term and intrusive Changes in anxiety levels Personality changes- e.g. quieter/ more introspective Greater anxiety about family/ friends Changing perception of death and value of life	*Personally, it stayed with me for a long, long time, because I could imagine it and I'd picture it in my mind, and the picture stayed with me for a long while of that. And it was grim, a grim picture. (Cath)*

	Ideas about death are more complex and subtle See lighter side of life as a result of suicide Therapeutic approach changed over time Taking more risks Less anxiety about 'getting it wrong' Reduced avoidance of 'unpleasant conservations' Increased willingness/comfort in exploring suicidality Increased trust/ confidence in practice/skills Increased intuition/ trusting intuition more over time Changing theoretical framework – moving to a working model rather than theory-based More willing to meet students where they are Greater desire to gain understanding the meaning of not wanting to be alive Increased focus on helping students 'notice' the 'alive' bit- greater attention to the part who 'wants to live' Greater vigilance/looking out for signals of risk	*I think it's made me closer to people in my team, who can hear the pressures and understand. (Beth)* *Maybe more willing to go there, always kind of knowing that yes, less likely to do anything if we talk about it. (Sue)* *My ideas of what it means to want to live or die has changed, it's a lot more subtle and complex now than it was. (Sophie)* *I think it's made the risk assessment has been more integral to my practice. (Hannah)*

Superordinate Theme 2: The context matters		
Subordinate themes	**Emergent themes**	**Sample of Quotes**
Organisational responses to suicide	Anxiety response to suicide Fear Shame Panic Sense of urgency Chaos in universities Initial reaction to want to bring in the experts Lack of awareness & knowledge Struggle to engage with topic Lack of ownership of suicide Lack of policies Reactive to suicide- Policy is created after suicide Policies provide clarity High anxiety among tutors- ill equipped	*It's something that's quite anxiety provoking in universities, and I think it's a really interesting subject because it kind of creates ripples throughout the university (Sophie)* *I think there are a particular set of pressures and often people work in very small, quite isolated communities, where there's pressure to teach (Beth)*

	Need for staff training Responsibility/accountability to the institution Blame on institution	*In the past there, there was a Chinese student, which kind of – there, there was a lot of activity around that. In, it – that anxiety, that organisational anxiety that I talk about. (Cath)* *I think as counsellors if we have the chance to go and do some training with academic staff and other staff in the institution, then that can really help because then we can get the appropriate referrals and people can start picking up the students that really need and could benefit from counselling. (Helen)* *I'm aware that with any death, particularly a suicide, there's likely to be a huge amount of anger flying around and that wants to be located somewhere. Whose fault was it? And it could get blamed on the institution (Toby)*
The university agenda	Conflicting agendas Student retention vs improving student welfare Cultural shifts Institution viewed as businesses Institution viewed as self-centred Institution- centric leads to de-personification of students Institutional need to manage fear Role to manage staff anxiety Reluctance to take responsibility or ownership of the risk Institutional focus on avoiding, stopping, or managing risk Expulsion of suicide by the institution Institutional struggle to own dark/ shadow side Defence against being scapegoated Powerlessness in therapists	*I think the institution struggles to own the shadow side of stuff, and we see a lot of it with staff, that actually the unhappiness, the institution doesn't own. (Beth)* *I think there's a lot of pressure on institutions to be seen to be responding. (Cath)* *There's quite a bit contrast, I'm interested in that myself really, about the difference between the way that the*

	Need to protect reputation Fear of negative publicity Institutional expectation to 'do something' Duty of care to student vs institutional needs Institutional judgment on what is deemed an appropriate intervention Institutional need for structure University agenda focused on student retention Lack of trust of institutional protection in event of suicide Unable to refuse support to suicidal students Questions about therapist competency Scrutiny Blame Need for justification	*institution holds student suicide and how therapeutically there's a...I think there's a very different way of working with it in the therapeutic side. (Sophie)* *I think institutions or maybe, I don't know about individuals, we seem to avoid the risk or stop it (Toby)* *We're operating in this context and we're sort of professional, you know, mental health workers, therapists, whatever, but in a university setting. It's really quite strange, you know, our business is not about research and it's not about education and there's a, there's a tension there (Cath)*
Universities' expectations of their counselling services	Expectation to offer a 'Fit for all' approach University seeks advice from counselling service during crises Unrealistic expectations of the counselling service Expectation that the counselling service will 'fix' things Expectation that the counselling service can 'stop' suicide Expect a 24-hour service from Counselling Perception counsellors are not doing enough Conflict between university expectations of counselling role Need for counselling to educate staff about expectations of the counselling service Poor relationship with internal departments Counselling service does not feel valued by other university depts Poor communication between depts Lack of clarity over what service offers Identification as a non-crisis service	*The problem is in institutions, by its nature, counselling silences itself. Because it's all confidential [laughs] (Beth)* *They're wanting to do the duty of care towards the student but it's in a panicky kind of way, in a kind of, almost like wanting the counselling service to rush over 'bring them here, you sort it out' that sort of thing. (Helen)* *There's the, the sort of – that we're perhaps not doing enough, that people would like to have emergency service (Cath)* *I think the college are very, very supportive of my role. (Sue)*

	Institutional poor understanding of counselling Silence of counselling service and confidential nature of counselling stops advocacy of the service	*I think there is something about working in an institution that might sometimes not have a great understanding of what counselling is. (Beth)*

Uncovering the multi-faceted layers of suicidal distress in universities	Exploration of existential issues/ belief systems Exploration of suicidality (increasing awareness of one's mortality) Exploration of identity concerns Sexuality struggles Autonomy/ developing independence Greater responsibility/concerns Period of experimentation Period of impulsivity Time of Transition/change Transient nature of student population Dealing with the unknown (starting a new life, having new experiences and unfamiliar environment for students) Inexperience/ Immaturity Students lacking robustness/resilience Myth of student life Age/ Life experience Academic pressures and expectations Binary thinking amongst students Fear of failure Financial pressures International students- high-risk Isolation	*I think there's more pressure, I think there's more instability, I think students have a lot more things to be bothered about than they used to, I do think the kind of melting pot of, like at this university you've got to be the best (Sophie)* *People getting drunk, people doing all sorts of things, relationship issues, not much life experience yet. A lot of pressure being in an institution, particularly like this. Peer pressure, competitiveness. Families are often quite dysfunctional. A lot of pressure from families sometimes. We've invested all this in you. Sometimes particularly the overseas students, very vulnerable. They're away from home, new environment, not familiar with the culture, all very strange. Don't know anybody, don't know how to get to know people. (Nadine)* *I think that things can change very radically for them very quickly, whether it's in their friendship groups, their academic work, their families (Hannah)* *Self-identity, sexuality, you know, it's – there's, there's so many things that people are – that students are*

		thinking about, exploring and questioning often, for the first time (Cath) *The other thing we get here is a lot of parents with extremely high expectations because it's a very middle-class university. Very high expectations of their kids. I've seen more clients who said I used to come home with 93 percent in my maths test and my father used to say where's the other seven percent? That kind of pressure, parental pressure which I think also adds into the mix. (Beth)*
Therapy challenges in HE	Unpredictability of suicidal distress Impulsivity- Playing Russian Roulette? Academic context- breaks Fear of discrimination Suicidal risk impact course progression Fitness to practise issues Reluctance to declare MH issues impacts access to support Concerns for students that their service *do not* know about Active role of study in the life of a student Hope associated with the life stage as a student Students' capacity for learning and change in therapy Increased capacity for change and opportunities for exploration	*They're a lovely group to work with, they really are, young people. Because there's a freshness and because they're learning and they're in a university, and so many of them, they're just geared to learn. …so they can take something and just work with it. (Beth)* *Students often are here for a term and go back home for the holidays, which means the therapy or counselling is discontinuous, particularly if they go to Europe or further afield, then it feels more… they're not just in London or whatever. Sometimes they don't come back into counselling as a result of that. (Toby)* *Working with students I think again is unique in the sense that they are somewhere, they are studying, so they have come to do something, it's not like they are sitting at home day in day out not doing anything, so there is that hope or that idea of why they have come to study, and quite a lot of the time*

		that can give them some kind of engagement with what they are doing, with how they're developing. (Helen) *Because we're a pressurised service and I think that sometimes they're perceived as difficult clients. I think that can be an issue as well, that somehow. (Beth)* *It is scary stuff, isn't it really, yes. (Sue)* *She really, really affect – really affected me, because that, that felt so real and there was something about the sort of small overdose, but multiple and, and it was almost sort of roulette that it might – one day she might just not quite – but she, she's, she's controlling it at the moment (Cath)*

Superordinate Theme 3: What helps?		
Subordinate themes	**Emergent themes**	**Sample of Quotes**
Sharing concerns	Need to share information Validating Reassurance Fulfils need for validation/reassurance from colleagues Personal distress leads to a narrowed perspective Feel less isolated Builds intimacy amongst colleagues Sharing informs the crisis plan-helpful	*Having that kind of collaboration, whether it's debriefing later, whether it's actually going and finding somebody, that can happen more on a duty day, where somebody's brought in or they arrive in a state, or they're in the emergency appointment slot and you're not quite sure, so having a collaborative team is really helpful (Hannah)* *I think generally just having, you know when it's like there's that question of 'is it at the point where I*

		need to disclose this or not?', to have other colleagues around really, on a very simple level really just to be able to say 'can I just run this past you, what do you think? My sense is this, what does it sound to you?', just to be able to do that, and to feel supported, it matters to me to feel supported by management, that I can kind of be clinically held with that. (Sophie) *It's another pair of eyes, isn't it, another pair of ears. Another perspective on things, at least one other perspective on how you see things. (Nadine)* *I was very shocked. It was a very shocking thing to hear. But I felt in the counselling team, I got a chance to talk about it in supervision and stuff. It felt quite easy to talk about (Beth)* *I do value my colleague's opinions, because sometimes you just think I should know what I've done – and the same with them to me. You know, I've done everything that I can do here, there's, there's, there's nothing, there's nothing else. (Cath)*
Support from others	Seek support from colleagues in times of distress Supportive colleagues Immediacy of on-site support Importance of a network of support Feel held by colleagues Supportive supervisor Trust in supervisory relationship Supervisor requirements/ role in supporting therapists	*Colleagues are great, I find the majority of the time colleagues will really hear you and want to know if you're okay and how that's impacting you and do you need any support, and help me make decisions (Sophie)*

	Supervisor role to contain anxiety/keep it out of the room Opportunity to process suicide in supervision Supervision as a shared space to talk Importance of Supervisor knowledge base Supervisor's attitude towards suicide is important Need for a calm and measured supervisor Need to feel held and supported Need to supervision in order to 'do the job' Supervision used as a form of alert Able to share vulnerability in supervision	*What you need is a supervisor who will be calm and measured. (Beth)* *I think generally just having, you know when it's like there's that question of 'is it at the point where I need to disclose this or not?', to have other colleagues around really, on a very simple level really just to be able to say 'can I just run this past you, what do you think? My sense is this, what does it sound to you?', just to be able to do that. (Sophie)* *My line manager knows and as I say, you know, he, he is supportive. (Sue)* *I mean my supervisor is there and I can talk to her about concerns and they're there, absolutely essential. (Helen)*
Previous experience of suicide	Fearless in sitting with suicide Preparedness/ readiness to engage with suicide due to own experience of others being fearful of talking about suicide with me- highlights usefulness of talking about suicide Increased immunity to suicide Greater awareness/ understanding of the despair and suffering associated with suicidal ideation (remember what it feels like) Interest in acute distress/ attracted to students with suicide risk Possibility of re-experiencing through the other Mindful of the idea that feelings can change over time – my feelings changes so what if a student changes their mind about suicide?	*It probably comes from quite a personal place because I felt suicidal in my teenage years (Nadine)* *When you work as a counsellor and you've worked with people who are really really struggling to see any point whatsoever in, in staying alive, their life feels so dreadful, I suppose I kind of – I know what – well I imagine what must go on before somebody actually completes suicide. (Sue)* *Certainly after it happened, I was much...I remember telling my supervisor, particularly with boys, that I wanted to just chain them all to my*

		radiator so I could keep an eye on them, because it was just terrifying. (Hannah) *The most profound experience was this senior work colleague who experienced it and it was him not talking about it that conveyed to me the impact of it. (Toby)* *I suppose what it feels like to be in a situation where you've got someone who has made that attempt and how it made me feel and the aftermath it was in the family, which was you know, obviously there was a lot that happened after that, so I mean that certainly, I'd not really thought about that before. (Helen)*
Self-care	Talking about suicide with others Family/friends as source of support Religion as a protective factor Use of humour to cope Support of colleagues/ sharing information about risk S/V and Therapy to process feelings Physical self-care strategies- e.g. sleep, food as a comfort, exercise x 5 (Walking by the sea, Dancing, Running) Meditation, gardening, reading, animals- pets Work part time- serves as a 'breather' Importance of leaving the counselling space/leaving things at work Acceptance of living with the risk of suicide as a occupational hazard Aim for a good work/life balance Need time for reflection of work Need for clear professional boundaries Need a reminder of what's 'normal' and 'good'	*Sometimes I will take on too many of it because I know I can do that, when I know I don't need to do that, so I have to remind myself sometimes 'it's okay, you don't have to save the world', not that I'm thinking I want to save the world but do you know what I mean, it's okay, you're doing your bit, so yeah if anything it's just being aware of that really. (Sophie)* *There are times when I do need time by myself, I wouldn't sort of want to be in company, need to kind of have a bit of me time, and I suppose people, because of my work (Helen)* *I go to bed and I read, go to bed and watch the telly.*

	Need to get out of your head/ switch off Need to compartmentalise feelings Need to share responsibility for risk	*It feels like a safe place for me to be in my bed. (Sue)* *I have to and I, I work part-time on – I don't know how my colleagues cope who work full-time doing it, five days a week, five clients a day. (Cath)* *being in an environment that has absolutely nothing to do with this kind of work you know, people from all walks of life who have allotments, just kind of reminding you of what's normal, what's good. (Hannah)*

Superordinate Theme 4: Barriers to supporting suicidal students in university counselling services		
Subordinate themes	**Emergent themes**	**Sample of Quotes**
Working under pressure	Institutional context offers constraints Lack of Resources Long counselling waiting lists No one is discharged on basis of high risk Priority given to high risk Nationwide problem Waiting list creates pressure and need to 'turnover'- makes risk is unbearable	*There are more people coming in with kind of mental health problems, with more complex conditions and all of that kind of thing and everyone's under a lot of pressure (Cath)* *There is a general pressure on resource. (Toby)* *I do wonder sometimes if other people are aware of what I hold. (Sue)* *I suppose if, if you, if you're aware that you've, you've had a busy week, you've had a busy day and I'd like to think that I'm, you know, that I would notice if I was going into a room and I wasn't*

		feeling in, in touch with the student, but there's a – you know, on a bad day it can feel a bit like processing people. (Cath) *What is very hindering is that services are so overstretched and we do sometimes feel as if we're monitoring risk rather than doing therapeutic work. (Hannah)*
(Too?) Brief Model	Challenges associated with brief model Institutional pressure to do brief work Need for managing expectations of what is achievable in brief model Responsibility falls on counsellor to manage services pressures independently Balancing student needs vs service pressures Brief work counters ethos of counselling? Internal conflict within therapist about brief therapy used to treat suicidal students -wish to extend work? Student dissatisfaction about brief therapy offer Changes in therapy role due to focus on brief work Change from counselling to monitoring/ managing risk? Therapist fear of becoming detached through reduced face-to-face work Greater focus on providing therapy rather than consultancy work Greater focus on one-to-one work rather than groups Freedom to *work* with suicidality (i.e. where focus is not on an ending)	*I think, organisationally, the greatest problem these days is the need for brief work, I mean the ethos is now, scarce resources have to be spread as far as possible (Helen)* *I need to have that freedom where I'm not thinking about the end in amongst it all. (Beth)* *I mean we work very individually but we are very much constrained by the institutions that we are in, and I think that isn't helpful, not all the time. (Helen)* *I'm just conscious of feeling irritated, thinking well, what is the message here. The message is keep everyone safe, but do it on as few sessions as you can. (Beth)* *It managed my anxiety and I escalated it up, because I'm within an organisation and then he did - sent the email and put it on the*

		database and we all go home. (Cath)
Managing suicide risk	Importance of relationship with manager Supportive and attentive line management Reassurance in having contact with manager Management expectations- to hold the line, to feel supported, to hold the therapist, to hold the risk Importance of a reporting line in the event of a crisis 'Weird' reaction to suicide from management 'Anxiety land' Management expectation of therapist to 'move on' the risk Lack of management holding Clinical responsibility pushed onto practitioner by management Management confusion about what to do Inward and outward facing role of management Double role of management Managers 'hands are tied' Discussion with management on decision-making re: risk increases pressure for therapist Careful in language use with management- linked to agenda to increase service offer Splitting - therapist preference to share suicidal case concerns with supervisor rather than manager	*To feel supported, it matters to me to feel supported by management, that I can kind of be clinically held with that (Sophie)* *I think managers tend to be very susceptible to that and tend to listen and then say 'yes but my hands are tied because of the resources, waiting lists are going to get this and this long if we do that'. (Helen)* *In this team it means that colleagues will talk to each other a lot more about it than they would to management; they're more likely to...not as much really, so it'll be like held out there. (Sophie)* *I can't trust the kind of line management bit entirely to be consistent. (Beth)*
Working and communication with external services	Fears of outsourcing Frequent liaison with NHS Accessibility to NHS services dependent on severity of suicidality Unpredictability of NHS Process of student bouncing back and forth between NHS and university Cuts in budgets/limited resources in NHS impacts treatment NHS miss the 'person' Communication difficulties Frustration with NHS	*We get it batted back quite a bit too, it usually doesn't come to that extent where you're, and I feel for the GPs because they don't have a lot of places they can send people either. (Hannah)* *Because we're time limited there's a pressure to get them seen somewhere else or held or to move the*

	Disbelief and anger with criteria for NHS referrals Comfort in involving statutory services Counsellor provides a missing piece of a jigsaw to the NHS Fear that things can get lost in the 'ether' between NHS and university University becomes container and fills the gaps for the NHS Institutional expectation to replace NHS/statutory services? Significant reduction in voluntary services to refer students on to Voluntary sector currently oversubscribed/ overwhelmed 'Fantasy' alternative of available resources Need for better communication with other parties Piecing information together between services	*risk away from the university to somewhere else (Sophie)* *There aren't places. There aren't a huge number of places to send people, necessarily. (Beth)* *I think the more joined up people are the better things go for the client. (Hannah)* *There was something about a sense of security about knowing that I am highlighting that this person has said something or done something or told me something, that is of concern and that that's not just lost in the ether, that there's a GP who, who has kind of responsibility for that person's care (Cath)*

Appendix 13: Dissemination 1-HUCS Survey Design

I identified key themes, which emerged from the semi-structured interviews with therapists and related to *management of suicide risk,* to devise a survey consisting of 9 questions. The key themes identified were:

- Service priorities
- Institutional policy
- Clinical responsibility
- Counsellor engagement in risk management decisions
- Support structures
- Key concerns in relation to working with student suicidality
- Areas identified for improvement to services
- Relationship between counselling service and university
- Suicide risk management

When devising the survey, I ensured that no raw data about the interviews was communicated to HUCS members and as such, the confidentiality and anonymity of the interview participants was protected.

Appendix 14: Dissemination 1-HUCS Survey

Survey on service provision for suicidal students in Higher Education

Reflecting on the service you provide to suicidal students, please complete the survey questions below:

1. ***What are the priorities of your service when working with suicidal students? E.g. tailoring service offer to meet students' needs, referring on students to statutory services, effective liaison with statutory services etc***

2. ***If a suicide policy/ procedural guideline is in place at your university, is it comprehensible and easily accessible to all?***

   Yes *No* *Don't know* *N/A*

3. ***Does clarity exist around who holds clinical responsibility within your service for managing a crisis with a suicidal student?***
   Yes *No*

4. ***Where students are deemed a high risk, are counsellors actively encouraged to engage in the decision-making process about the service response to the risk presented?***
   Yes *No*

5. ***What structures are in place (if any) to support your team in managing high-risk students?***

6. ***What are the key areas of concern in your service in respect to working with suicidal students?***

7. ***What are the areas that you have identified for improvement in respect to working with suicidal students?***

8. ***How would you describe the relationship between your service and other departments within your university when managing risk?***

9. ***How do you personally feel about managing risk in your service?***

10. **Please feel free to make any additional comments:**

……

……

Appendix 15: Dissemination 1-Recruitment Email for HUCS Survey

FAO: HEADS OF COUNSELLING SERVICES IN HIGHER EDUCATION

Call for Participants!

Survey on service provision for suicidal students in Higher Education

I am a doctoral student from Metanoia Institute, London, and currently in the final stages of writing up my doctoral research titled 'Therapists' experiences of working with suicidal students in Higher Education'.

For this small-scale study, I used semi-structured interviews to explore therapists' experiences of working with suicidal students in Higher Education. Following data analysis, I used the main findings from my semi-structured interviews to devise survey questions aimed for Heads of Counselling services in Higher Education institutions across the UK. It is hoped that the survey will serve as an opportunity for Heads of Counselling services to reflect on service provision for suicidal students within their own institutions. Please note that I hope to disseminate the complete findings from my doctoral research via relevant conferences in the sector in the coming months.

I would now like to invite Heads of Counselling Services in Higher Education to complete the short survey below. The survey should take approx. 10 minutes to complete and identities of participants and their institutions will remain anonymous throughout.

Note: This doctoral thesis is being supervised by Andrew Reeves and approval for this research has been granted by the Metanoia Institute, London.

Please click on or copy the link below to complete the survey:

LINK TO SURVEY: https://www.surveymonkey.co.uk/r/KYVNXXC

Many thanks in advance for your contribution to this survey.

Warm regards,

Sonia Avasthi

Qualified Clinical Integrative Psychotherapist

Appendix 16: Dissemination 1-HUCS Survey Findings

GROUP RESPONSES

Q.1. Service priorities when working with suicidal students

Service priorities were centred on assessing the suicidal risk in a timely manner and considering which service might best meet the needs of the student. Every member also highlighted the importance of onward referral and effective liaison with statutory services.

Q.2 Suicide Policy

Half of the members agreed that their suicidal policy in place was clear and easily accessible to all. The other half reported that no policy was in place.

Q.3 Clinical responsibility

3 of the 4 members felt that clarity existed around who held clinical responsibility within their service for managing a crisis with a suicidal student, whereas 1 member felt there was a lack of clarity around clinical responsibility.

Q.4 Counsellor engagement in the decision-making process about risk management

All members asserted that counsellors in their service were actively encouraged to engage in the decision-making process about the service response.

Q. 5 Structures to support teams in managing high-risk students

Support structures included senior management, HUCS members themselves, peer support and clinical supervision. Other supports included an ‘At- risk register’, bi-weekly conferences, clear policy, multidisciplinary team input and a 'duty' service for suicidal cases.

Q. 6 Key areas of concerns with respect to working with suicidal students

2 members highlighted the scarcity of resources for suicidal students, both in-house and externally. Seen as a ‘go-to' service for suicidal students, they questioned the role of HE counselling services meeting the shortfalls in the NHS care. Another member called for more joined-up thinking across the university and the need for senior management to manage pressures more effectively in order to ensure that potential suicide risk is ‘managed calmly and not over-reactively’. Finally, 1 member spoke about the need to assess risk and explore ways to mitigate against risk in timely manner.

Q. 7 Areas identified for improvement with respect to working with suicidal students

2 members identified *appropriate referral* and *liaison with external services* as areas for improvement, whereas for another member stated that *improved communication across the university* was needed. 1 member felt that *clearer lines of responsibility* needed to be established within their service and efforts needed to be made to continue to *improve access to suicidal students* who were ambivalent about seeking support.

Q. 8 Relationship between counselling service and wider university departments
All members reported positive relationships between their services and the wider university in regard to managing risk. Despite this, 3 out of 4 members noted high levels of anxiety in non-clinical staff and highlighted the possibility of 'misplaced expectations' about the service offer.

Q.9 Personal reflections about managing suicidal risk in the service
3 out of 4 members accepted the inevitability of managing risk as a part of their role. 1 member divulged that suicide risk would always be a concern, regardless of good systems and communication. Another member voiced their feelings of injustice about universities being scapegoated due to insufficient resources in the NHS. 2 members experienced pressures *to do something* about suicide risk, particularly from senior management who had concerns that non-action would impact negatively on the reputation of the university.

INDIVIDUAL RESPONSES

Participant 1

Q1
What are the priorities of your service when working with suicidal students? E.g. tailoring service offer to meet students' needs, referring on students to statutory services, effective liaison with statutory services etc
Ensuring safety of students: making a safety plan, ensuring engagement with support (both from our service and NHS etc), referring students to GP or crisis services, liaison with statutory services, therapeutic support to decrease suicidality.

Q2
If a suicide policy/ procedural guideline is in place at your university, is it comprehensible and easily accessible to all?
Yes

Q3
Does clarity exist around who holds clinical responsibility within your service for managing a crisis with a suicidal student?
Yes

Q4

Where students are deemed a high risk, are counsellors actively encouraged to engage in the decision-making process about the service response to the risk presented?
Yes

Q5
What structures are in place (if any) to support your team in managing high-risk students?
Clear lines of escalation and consistent availability of management support, clear and comprehensive procedures, multidisciplinary team input, 'Duty' service for urgent cases, good prioritisation of at risk clients in terms of urgent appointments, clinical supervision, cross university services liaison and collaboration, information about crisis services freely available to all, good relationship and liaison with on campus GPs, liaison with statutory services.

Q6
What are the key areas of concern in your service in respect to working with suicidal students?
Lack of resources of local CMHRS means that many students who are clearly at risk (e.g. have recently made serious attempt) do not get sufficient support. Lack of support from NHS services of high risk students with personality disorders. I am concerned about blame being placed on universities for what are shortfalls in NHS care. We should not be asked to provide NHS services as we are not clinical services. Also concerned about calls for 'opt in' to contact parents - this may well put many at risk students off coming for support.

Q7
What are the areas that you have identified for improvement in respect to working with suicidal students?
I feel as a service we work pretty well with suicidal risk - of course there's always room for improvement. We always need to engage in ongoing training regarding working with risk. Would like to reach the students who don't come forward for support - have schemes in place to try to do this, but could continue to improve access. We do need more from the CMHRS though, as above.

Q8
How would you describe the relationship between your service and other departments within your university when managing risk?
Good - non clinical staff are very anxious about risk. They know to phone us for advice etc. We have weekly meeting with other services within the university to discuss care of high profile cases, bearing in mind confidentiality etc.fr

Q9
How do you personally feel about managing risk in your service?
I feel we manage it well. We work with a lot of risk however, and this is a pressure upon clinicians. We have insufficient support from NHS services, although are GPs are very good. The scapegoating of universities for student suicides is unfair I think - there are fewer suicides among students than among the general population of this age.
Participant 2

Q1
What are the priorities of your service when working with suicidal students? E.g. tailoring service offer to meet students' needs, referring on students to statutory services, effective liaison with statutory services etc
Assessing risk and support available, whether the student can be contained within the limits of the service available, if not supporting the student to access support externally and promptly, with perhaps holding arrangements in the meantime

Q2
If a suicide policy/ procedural guideline is in place at your university, is it comprehensible and easily accessible to all?
Not applicable as no policy in place

Q3
Does clarity exist around who holds clinical responsibility within your service for managing a crisis with a suicidal student?
No

Q4
Where students are deemed a high risk, are counsellors actively encouraged to engage in the decision-making process about the service response to the risk presented?
Yes

Q5
What structures are in place (if any) to support your team in managing high-risk students?
Visiting psychiatrist, supervision, peer support, support of head of department, external resources ps suicide risk management policy in development

Q6
What are the key areas of concern in your service in respect to working with suicidal students?
Pressure from senior management to reduce risk, sometimes to disclose details, lack of joined up thinking within the institution so risk is managed calmly and not over-reactively

Q7
What are the areas that you have identified for improvement in respect to working with suicidal students?
Clearer lines of responsibility, more communication about responding to students expressing suicidal thoughts, more options for long term support

Q8
How would you describe the relationship between your service and other departments within your university when managing risk?
Generally relationships are constructive, though there can be misplaced expectations as to what the service can offer/deliver eg if the student is reluctant to access help

Q9
How do you personally feel about managing risk in your service?
Risk is always present and I am never complacent! However good the communication and systems are suicide risk is always a concern. I am aware of the pressure to 'do something' to take away others' anxiety which is not always possible

Q10
Please feel free to make any additional comments here
I think the current terminology of zero tolerance of suicide or of prevention can be unhelpful in reducing a space for thinking and understanding

Participant 3

Q1

What are the priorities of your service when working with suicidal students? E.g. tailoring service offer to meet students' needs, referring on students to statutory services, effective liaison with statutory services etc
Understanding the level of risk and exploring ways to mitigate this where possible. This may include liaising with other services internally or externally and/or referring the student.

Q2
If a suicide policy/ procedural guideline is in place at your university, is it comprehensible and easily accessible to all?
Not applicable as no policy in place

Q3
Does clarity exist around who holds clinical responsibility within your service for managing a crisis with a suicidal student?
Yes

Q4
Where students are deemed a high risk, are counsellors actively encouraged to engage in the decision-making process about the service response to the risk presented?
Yes

Q5
What structures are in place (if any) to support your team in managing high-risk students?
Students deemed to be at higher levels of risk must be 'escalated' to the service manager/clinical lead in all cases where discussion will take place with the clinician working with the student to explore the best way to support them. Where appropriate, students may be added to the university 'At-Risk' register (maintained by several services) and their case discussed in fortnightly conferences to determine the best way forward.
Q6
What are the key areas of concern in your service in respect to working with suicidal students?
Ensuring that it is understood what the degree of risk is and ensuring that we explore how to mitigate or minimise that risk as soon as possible.

Q7
What are the areas that you have identified for improvement in respect to working with suicidal students?
Ensuring appropriate referral or liaison with external bodies where needed (e.g. GP or other mental health services)
Q8
How would you describe the relationship between your service and other departments within your university when managing risk?
Many staff in other services will go into 'panic mode' as soon as they are overwhelming issues of risk and expect an immediate response. We presently employ a single member of staff to act as the main liaison with staff to enable 'triaging' of issues and to provide practical/emotional support to staff to try to reassure and support them as best as possible.

Q9
How do you personally feel about managing risk in your service?
'Risk' is a very broad term and isn't always clear what this entails. Whilst I feel confident dealing with most issues of risk, management in the university are often concerned about reputation and whether non-action will harm the reputation of the university.

Participant 4

Q1
What are the priorities of your service when working with suicidal students? E.g. tailoring service offer to meet students' needs, referring on students to statutory services, effective liaison with statutory services etc
Having contact with them asap. Deciding next steps which will most likely be a referral on to statutory services

Q2
If a suicide policy/ procedural guideline is in place at your university, is it comprehensible and easily accessible to all?
Yes

Q3
Does clarity exist around who holds clinical responsibility within your service for managing a crisis with a suicidal student?
Yes

Q4
Where students are deemed a high risk, are counsellors actively encouraged to engage in the decision-making process about the service response to the risk presented?
Yes

Q5
What structures are in place (if any) to support your team in managing high-risk students?
Line management; peer support; regular case meetings; clinical supervision

Q6
What are the key areas of concern in your service in respect to working with suicidal students?
capacity of service and that sometimes we are seen as the "go to" service for suicidal clients

Q7
What are the areas that you have identified for improvement in respect to working with suicidal students?
more joined up comms within the university as a whole

Q8
How would you describe the relationship between your service and other departments within your university when managing risk?
generally good

Q9
How do you personally feel about managing risk in your service?
It is part of the job

Q10
Please feel free to make any additional comments here
The questions were a bit vague-but worth asking

Appendix 17: Dissemination 2-Presentation Notes

PRESENTATION OUTLINE

1.30pm	Introductions (10 mins)
1.40pm	Activity 1- Icebreaker (5 mins)
1.45pm	Pair work (10 mins)
1.55pm	Feedback (5 mins)
2pm	Research presentation (30 mins)
2.30pm	Q & A/ Discussion (20 mins)
2.50pm	Activity 2 (10 mins)
3pm	Feedback and final questions (10 mins)
3.10pm	Metaphors – around the room (5 mins)
3.30pm	Close

INTRODUCTION

- Doctorate in Counselling Psychology at Metanoia for 7 years
- Psychotherapist- recently qualified
- Spent 11 years working as a Mental Health Adviser at HEI
- Also worked as a Student Counsellor for 5 years at another HEI
- Currently working for HEI- a relatively new US university set up to offer education on various sites internationally.
- Thinking about the research today for the past 8 years

MY INTENTION
My hope is that that this session will be a way to start a conversation about suicide.

SENSITIVE SUBJECT
I appreciate this is a difficult subject to think and discuss, but I also hope that there is some value/benefit in discussing what is seen to be taboo for most people.

Please feel free to step out and take a break if at all necessary.

CONFIDENTIALITY
This is a sensitive area- rest assured that full confidentiality will be maintained. Let's keep things in the room.

FEEDBACK IS WELCOMED

Please email comments or thoughts back to me

EXERCISE 1
I would like to start by asking everyone to do a short exercise.
I hope that this might be one way of starting to bring the topic of my research alive and bringing suicide into the room.

Contemplation activity

Sit comfortably…….Relax……. you might want to close your eyes and just relax for a few seconds

Now I want you to think about the word suicide…..

Notice what comes up for you?

Notice what happens to your body? Your bodily responses to the word suicide?

Pay attention to them- what are they telling you?
Where does your mind go? What thoughts come up for you?

Or maybe there are images that come up for you instead?

How do you feel? Again pay attention to them…..

I would like you now to spend the next 3 minutes simply contemplating on the word suicide, stay curious, and see what comes to the surface for you.

I will tell you when the three minutes are up, and we can then move on to the next exercise.

In pairs: I would like you to work in pairs and discuss what came up for you during the short exercise (if you feel comfortable, and if you don't, talk around what it is that is difficult to voice).

MY RESEARCH PROJECT

Intro
I am going to talk today about my project which explores the lived experience of therapists who work with suicidal students

Why did I want to study this?
My journey with this subject started 8 years ago- I experienced a student suicide when I worked as a MHA
Background to suicide
Saw him once for an assessment

Ended his life approx. 5 months later

My response

Very shocked
It challenged my own omnipotence as a MENTAL HEALTH ADVISER- the idea that someone could actually die was foreign to me- naivety
It brought suicide into the room- into the service

Had a very profound impact on me personally
Questions arose for me around life and death- tapped into my own mortality
Questioned my own suicidal parts

Team response

I was curious about how my team and other people at the university responded to the suicide….some colleagues questioning 'why are you upset'?

I noticed that as a team, we disowned suicide, brushed it under the carpet- left fragmented and undigested. I wondered, 'If we can't work with it as a counselling service, what does that mean for the institution?'

Where am I now in research process?

Writing up stage- initial data analysed

Questions??

There will be time at the end of the presentation to ask any Q's about my research.

EXERCISE 2

In pairs, reflect on what personal factors in your life have shaped and influenced your views on suicide? (10 mins)

(religious beliefs, cultural attitudes, experience of familial suicide, personal history, life philosophy)

Feedback

How did people find the exercise? Would anyone like to share their experience?

If the exercise was hard to do for whatever reason, I would encourage you to think about the reason for this further, outside of this session.

CLOSE

As we close, let's consider what metaphor/s would you use to describe your work with suicidal students?
Final thoughts:

I’m aware that we have tried to ask very big questions today, but I hope this can be seen as an initial discussion which could lead to further food for thought later on….

As the session closes, I would ask you to pay attention to how you feel in your body

And……

Reflect on what is your relationship to suicide and your suicidal parts?